

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 3,6 Film G195 1-19-56 et  
4176 CERTIFICATE OF DEATH

04144

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Chatham</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>83X-3</i> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>50 MIH - NINDB</i>		d. STREET ADDRESS <i>Vite #</i>	
3. NAME OF DECEASED (Type or print) First <i>Ashley</i> Middle <i>Omer</i> Last <i>Allen</i>		4. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>WHITE W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 April 1903</i>
9. AGE (In years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR: Months <i>52</i> Days <i>52</i> Hours <i>52</i> Min. <i>52</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>UNKNOWN Alonza Allen</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN Sally Fathera</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Chart. Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central Respiratory</i> <i>193X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Glioma Brain Stem.</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August, 1955</i> , to <i>7 April, 1956</i> , that I last saw the deceased alive on <i>7 April, 1956</i> , and that death occurred at <i>9:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. Laskowski</i> M.D.		ADDRESS (Street, city or town, state) <i>720 Center Drive Bethesda</i> DATE SIGNED <i>8 April 56</i>	
PHYSICIAN'S NAME (Type) <i>E. J. Laskowski</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/11/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Allen Family Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pittsylvania Co., Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Mary.</i>		24a. REC'D BY REGISTRAR <i>Calvin A. Pumphrey</i> DATE <i>4/10/56</i>	
24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>			

010122-1.00 1400000

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

[illegible]

BUREAU V. S.

APR 12 1956

RECEIVED



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		NONE		NONE		NONE	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MOTHER		FATHER		SIBLINGS	
CONDUCTOR		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE		NONE	
DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE		MANNER OF DEATH OF SPOUSE		DISEASE OR INJURY OF SPOUSE		MEDICAL HISTORY OF SPOUSE		PREVIOUS ILLNESS OF SPOUSE	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN		DATE OF LAST DENTIST VISIT		NAME OF DENTIST		DATE OF LAST OPTICIAN VISIT		NAME OF OPTICIAN		DATE OF LAST PODIATRIST VISIT		NAME OF PODIATRIST	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST HOSPITALIZATION		NAME OF HOSPITAL		DATE OF LAST SURGERY		NAME OF SURGEON		DATE OF LAST ANESTHESIA		NAME OF ANESTHESIOLOGIST		DATE OF LAST X-RAY		NAME OF RADIOLOGIST	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST AUTOPSY		NAME OF PATHOLOGIST		DATE OF LAST TOXICOLOGY		NAME OF TOXICOLOGIST		DATE OF LAST FORENSIC		NAME OF FORENSIC		DATE OF LAST MEDICAL		NAME OF MEDICAL	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST MENTAL		NAME OF PSYCHIATRIST		DATE OF LAST PSYCHOLOGICAL		NAME OF PSYCHOLOGIST		DATE OF LAST SOCIAL		NAME OF SOCIAL		DATE OF LAST NUTRITIONAL		NAME OF NUTRITIONIST	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN		DATE OF LAST DENTIST VISIT		NAME OF DENTIST		DATE OF LAST OPTICIAN VISIT		NAME OF OPTICIAN		DATE OF LAST PODIATRIST VISIT		NAME OF PODIATRIST	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST HOSPITALIZATION		NAME OF HOSPITAL		DATE OF LAST SURGERY		NAME OF SURGEON		DATE OF LAST ANESTHESIA		NAME OF ANESTHESIOLOGIST		DATE OF LAST X-RAY		NAME OF RADIOLOGIST	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST AUTOPSY		NAME OF PATHOLOGIST		DATE OF LAST TOXICOLOGY		NAME OF TOXICOLOGIST		DATE OF LAST FORENSIC		NAME OF FORENSIC		DATE OF LAST MEDICAL		NAME OF MEDICAL	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF LAST MENTAL		NAME OF PSYCHIATRIST		DATE OF LAST PSYCHOLOGICAL		NAME OF PSYCHOLOGIST		DATE OF LAST SOCIAL		NAME OF SOCIAL		DATE OF LAST NUTRITIONAL		NAME OF NUTRITIONIST	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	

BUREAU V. E.

MAY 7 1968

RECEIVED



4178

## CERTIFICATE OF DEATH

041464

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURTONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>(SUPPENNY) PEOPLE'S DRUG STORE</b>		d. STREET ADDRESS <b>OURSLEY ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>SMITH</b> Middle <b>W.</b> Last <b>ALLNUTT</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 18, 1886.</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GEN. REAL ESTATE</b>	
11. BIRTHPLACE (State or foreign country) <b>DAWSONVILLE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWIN R. ALLNUTT</b>		14. MOTHER'S MAIDEN NAME <b>ANNA CHISWELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. MARGARET W. ALLNUTT, BURTONSVILLE, MD.</b>		Address <b>OURSLEY ROAD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> 19 <b>55</b> to <b>13 April</b> 19 <b>56</b> , that I last saw the deceased alive on <b>13 April</b> 19 <b>56</b> , and that death occurred at <b>12:20 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		ADDRESS (Street, city or town, state) <b>906 Clearville Rd Silver Spring, Md.</b> DATE SIGNED <b>4/13/56</b>	
PHYSICIAN'S NAME (Type) <b>William D. Aud</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>APR 16, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>	22d. LOCATION (City, town, or county) <b>BURTONSVILLE, CO. MONTGOMERY MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Baller</b>		24a. REC'D BY REGISTRAR <b>TAKOMA</b>	24b. REGISTRAR'S SIGNATURE <b>Francis J. Baller</b>
ADDRESS <b>254 Carroll St. N.W. PARK DC</b>		DATE <b>4/14/56</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1995


BUREAU V. S.

APR 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4179

## CERTIFICATE OF DEATH

04147

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broke Grove Chronic Hospital</u>		d. STREET ADDRESS <u>1607 Moyes Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Dollie</u> Middle <u>F</u> (Altomus) Last <u>Altomus</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A-</u>	
13. FATHER'S NAME <u>Edgar E. Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Dora J. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Patient</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. PERITONITIS</u> DUE TO <u>PERFORATED ABDOMINAL VISCERA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>FAR ADVANCED CA-STOMACH</u> (c) <u>5 YRS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 1, 1954</u> to <u>APR. 16, 1956</u> that I last saw the deceased alive on <u>APR. 15, 1956</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>16 Apr 56</u>	
PHYSICIAN'S NAME (Type) <u>DR. T. B. Ziegler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/20/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. W. Niles Co</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 4-18-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bertrude B. Lawler</u>

CERTIFICATE OF DEATH

NAME OF DECEASED: *John F. Hooker*  
AGE: *70*  
SEX: *M*  
DATE OF BIRTH: *March 20, 1885*  
PLACE OF BIRTH: *St. Louis, Mo.*  
OCCUPATION: *Retired*  
RESIDENCE: *142 S. H. Avenue, Baltimore, Md.*  
CAUSE OF DEATH: *Heart Failure*  
DATE OF DEATH: *April 10, 1956*  
PLACE OF DEATH: *Home*  
SIGNATURE OF PHYSICIAN: *[Signature]*  
SIGNATURE OF REGISTRAR: *[Signature]*

DATE OF DEATH: *April 10, 1956*  
TIME OF DEATH: *10:45 AM*  
PLACE OF DEATH: *Home*  
CAUSE OF DEATH: *Heart Failure*  
MANNER OF DEATH: *Natural*  
SIGNATURE OF PHYSICIAN: *[Signature]*  
SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. S.

APR 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04148

4180

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>822 Richmond Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Draper Wilson Armstrong</u>		4. DATE OF DEATH Month Day Year <u>April 5 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home modernizing</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLEY A. <del>WILKINSON</del> Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>KATE E. Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>104-05-0929</u>	
17. INFORMANT <u>Wife - Mrs. Gladys Armstrong</u>		Address <u>822 Richmond Ave., Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>10915</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERMITTENT ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>56</u> , to <u>4-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>56</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10644 Conn. Ave. Kensington, Md. 4-5-56</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		24a. REC'D BY REGISTRAR DATE <u>4/7/56</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. [illegible]		2. SEX Male		3. AGE [illegible]	
4. PLACE OF BIRTH [illegible]		5. DATE OF BIRTH [illegible]		6. PLACE OF DEATH [illegible]	
7. OCCUPATION [illegible]		8. CAUSE OF DEATH [illegible]		9. MANNER OF DEATH [illegible]	
10. SIGNATURE OF PHYSICIAN [illegible]		11. SIGNATURE OF REGISTRAR [illegible]		12. SIGNATURE OF WITNESS [illegible]	
13. DATE OF DEATH [illegible]		14. TIME OF DEATH [illegible]		15. PLACE OF INTERMENT [illegible]	
16. NAME OF CEMETERY OR CREMATOR [illegible]		17. NAME OF FUNERAL HOME [illegible]		18. NAME OF UNDERTAKER [illegible]	
19. NAME OF NEXT OF KIN [illegible]		20. ADDRESS OF NEXT OF KIN [illegible]		21. CITY AND STATE OF NEXT OF KIN [illegible]	
22. NAME OF DECEASED'S MOTHER [illegible]		23. ADDRESS OF DECEASED'S MOTHER [illegible]		24. CITY AND STATE OF DECEASED'S MOTHER [illegible]	
25. NAME OF DECEASED'S FATHER [illegible]		26. ADDRESS OF DECEASED'S FATHER [illegible]		27. CITY AND STATE OF DECEASED'S FATHER [illegible]	
28. NAME OF DECEASED'S SPOUSE [illegible]		29. ADDRESS OF DECEASED'S SPOUSE [illegible]		30. CITY AND STATE OF DECEASED'S SPOUSE [illegible]	
31. NAME OF DECEASED'S CHILDREN [illegible]		32. ADDRESS OF DECEASED'S CHILDREN [illegible]		33. CITY AND STATE OF DECEASED'S CHILDREN [illegible]	
34. NAME OF DECEASED'S BROTHERS [illegible]		35. ADDRESS OF DECEASED'S BROTHERS [illegible]		36. CITY AND STATE OF DECEASED'S BROTHERS [illegible]	
37. NAME OF DECEASED'S SISTERS [illegible]		38. ADDRESS OF DECEASED'S SISTERS [illegible]		39. CITY AND STATE OF DECEASED'S SISTERS [illegible]	
40. NAME OF DECEASED'S UNCLE [illegible]		41. ADDRESS OF DECEASED'S UNCLE [illegible]		42. CITY AND STATE OF DECEASED'S UNCLE [illegible]	
43. NAME OF DECEASED'S AUNT [illegible]		44. ADDRESS OF DECEASED'S AUNT [illegible]		45. CITY AND STATE OF DECEASED'S AUNT [illegible]	
46. NAME OF DECEASED'S GRANDFATHER [illegible]		47. ADDRESS OF DECEASED'S GRANDFATHER [illegible]		48. CITY AND STATE OF DECEASED'S GRANDFATHER [illegible]	
49. NAME OF DECEASED'S GRANDMOTHER [illegible]		50. ADDRESS OF DECEASED'S GRANDMOTHER [illegible]		51. CITY AND STATE OF DECEASED'S GRANDMOTHER [illegible]	
52. NAME OF DECEASED'S GREAT-GRANDFATHER [illegible]		53. ADDRESS OF DECEASED'S GREAT-GRANDFATHER [illegible]		54. CITY AND STATE OF DECEASED'S GREAT-GRANDFATHER [illegible]	
55. NAME OF DECEASED'S GREAT-GRANDMOTHER [illegible]		56. ADDRESS OF DECEASED'S GREAT-GRANDMOTHER [illegible]		57. CITY AND STATE OF DECEASED'S GREAT-GRANDMOTHER [illegible]	
58. NAME OF DECEASED'S GREAT-UNCLE [illegible]		59. ADDRESS OF DECEASED'S GREAT-UNCLE [illegible]		60. CITY AND STATE OF DECEASED'S GREAT-UNCLE [illegible]	
61. NAME OF DECEASED'S GREAT-AUNT [illegible]		62. ADDRESS OF DECEASED'S GREAT-AUNT [illegible]		63. CITY AND STATE OF DECEASED'S GREAT-AUNT [illegible]	
64. NAME OF DECEASED'S GREAT-GRANDFATHER [illegible]		65. ADDRESS OF DECEASED'S GREAT-GRANDFATHER [illegible]		66. CITY AND STATE OF DECEASED'S GREAT-GRANDFATHER [illegible]	
67. NAME OF DECEASED'S GREAT-GRANDMOTHER [illegible]		68. ADDRESS OF DECEASED'S GREAT-GRANDMOTHER [illegible]		69. CITY AND STATE OF DECEASED'S GREAT-GRANDMOTHER [illegible]	
70. NAME OF DECEASED'S GREAT-UNCLE [illegible]		71. ADDRESS OF DECEASED'S GREAT-UNCLE [illegible]		72. CITY AND STATE OF DECEASED'S GREAT-UNCLE [illegible]	
73. NAME OF DECEASED'S GREAT-AUNT [illegible]		74. ADDRESS OF DECEASED'S GREAT-AUNT [illegible]		75. CITY AND STATE OF DECEASED'S GREAT-AUNT [illegible]	
76. NAME OF DECEASED'S GREAT-GRANDFATHER [illegible]		77. ADDRESS OF DECEASED'S GREAT-GRANDFATHER [illegible]		78. CITY AND STATE OF DECEASED'S GREAT-GRANDFATHER [illegible]	
79. NAME OF DECEASED'S GREAT-GRANDMOTHER [illegible]		80. ADDRESS OF DECEASED'S GREAT-GRANDMOTHER [illegible]		81. CITY AND STATE OF DECEASED'S GREAT-GRANDMOTHER [illegible]	
82. NAME OF DECEASED'S GREAT-UNCLE [illegible]		83. ADDRESS OF DECEASED'S GREAT-UNCLE [illegible]		84. CITY AND STATE OF DECEASED'S GREAT-UNCLE [illegible]	
85. NAME OF DECEASED'S GREAT-AUNT [illegible]		86. ADDRESS OF DECEASED'S GREAT-AUNT [illegible]		87. CITY AND STATE OF DECEASED'S GREAT-AUNT [illegible]	
88. NAME OF DECEASED'S GREAT-GRANDFATHER [illegible]		89. ADDRESS OF DECEASED'S GREAT-GRANDFATHER [illegible]		90. CITY AND STATE OF DECEASED'S GREAT-GRANDFATHER [illegible]	
91. NAME OF DECEASED'S GREAT-GRANDMOTHER [illegible]		92. ADDRESS OF DECEASED'S GREAT-GRANDMOTHER [illegible]		93. CITY AND STATE OF DECEASED'S GREAT-GRANDMOTHER [illegible]	
94. NAME OF DECEASED'S GREAT-UNCLE [illegible]		95. ADDRESS OF DECEASED'S GREAT-UNCLE [illegible]		96. CITY AND STATE OF DECEASED'S GREAT-UNCLE [illegible]	
97. NAME OF DECEASED'S GREAT-AUNT [illegible]		98. ADDRESS OF DECEASED'S GREAT-AUNT [illegible]		99. CITY AND STATE OF DECEASED'S GREAT-AUNT [illegible]	
100. NAME OF DECEASED'S GREAT-GRANDFATHER [illegible]		101. ADDRESS OF DECEASED'S GREAT-GRANDFATHER [illegible]		102. CITY AND STATE OF DECEASED'S GREAT-GRANDFATHER [illegible]	

1

BUREAU V. S.

APR 9 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4181 CERTIFICATE OF DEATH

04149

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN KENSINGTON		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS KENSINGTON GARDENS REST HOME				STREET ADDRESS 3133 CONNECTICUT AVE. ✓			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) LUCY M. F. ASHTON				4. DATE OF DEATH (Month) (Day) (Year) APRIL 30 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 6/16/69	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) FRANKLIN CITY MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN PERKINS				14. MOTHER'S MAIDEN NAME SUSAN BELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. ESTHER A. WILSON 3133 CONN. AVE., N.W., WASHINGTON, D.C.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 wks			
450.0 IMMEDIATE CAUSE (A) Congestive heart failure							
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral art. Sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Generalized art. Sclerosis							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAY 19 51, to 30 APR 19 56, that I last saw the deceased alive on 26 APR 19 56, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE Charles W. Thompson M.D.				DATE SIGNED 1714-N-3-W Wash. D.C. / May 3			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		DATE THEREOF 5/1/56		NAME OF CEMETERY OR CREMATORY WILDWOOD CEMETERY		LOCATION (City, town, or county) (State) BARTOW, POLK COUNTY, FLORIDA	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Frances Patten		25. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
DATE 5/2/56							

# CERTIFICATE OF DEATH

Date of Death

1. Name of Deceased		2. Sex		3. Age	
4. Date of Birth		5. Place of Birth		6. Date of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Registrar	
10. Signature of Physician		11. Signature of Coroner		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Cemetery		15. Signature of Funeral Home	
16. Signature of Mortician		17. Signature of Embalmer		18. Signature of Crematorium	
19. Signature of Burial Society		20. Signature of Cemetery		21. Signature of Funeral Home	
22. Signature of Mortician		23. Signature of Embalmer		24. Signature of Crematorium	
25. Signature of Burial Society		26. Signature of Cemetery		27. Signature of Funeral Home	
28. Signature of Mortician		29. Signature of Embalmer		30. Signature of Crematorium	
31. Signature of Burial Society		32. Signature of Cemetery		33. Signature of Funeral Home	
34. Signature of Mortician		35. Signature of Embalmer		36. Signature of Crematorium	
37. Signature of Burial Society		38. Signature of Cemetery		39. Signature of Funeral Home	
40. Signature of Mortician		41. Signature of Embalmer		42. Signature of Crematorium	
43. Signature of Burial Society		44. Signature of Cemetery		45. Signature of Funeral Home	
46. Signature of Mortician		47. Signature of Embalmer		48. Signature of Crematorium	
49. Signature of Burial Society		50. Signature of Cemetery		51. Signature of Funeral Home	
52. Signature of Mortician		53. Signature of Embalmer		54. Signature of Crematorium	
55. Signature of Burial Society		56. Signature of Cemetery		57. Signature of Funeral Home	
58. Signature of Mortician		59. Signature of Embalmer		60. Signature of Crematorium	
61. Signature of Burial Society		62. Signature of Cemetery		63. Signature of Funeral Home	
64. Signature of Mortician		65. Signature of Embalmer		66. Signature of Crematorium	
67. Signature of Burial Society		68. Signature of Cemetery		69. Signature of Funeral Home	
70. Signature of Mortician		71. Signature of Embalmer		72. Signature of Crematorium	
73. Signature of Burial Society		74. Signature of Cemetery		75. Signature of Funeral Home	
76. Signature of Mortician		77. Signature of Embalmer		78. Signature of Crematorium	
79. Signature of Burial Society		80. Signature of Cemetery		81. Signature of Funeral Home	
82. Signature of Mortician		83. Signature of Embalmer		84. Signature of Crematorium	
85. Signature of Burial Society		86. Signature of Cemetery		87. Signature of Funeral Home	
88. Signature of Mortician		89. Signature of Embalmer		90. Signature of Crematorium	
91. Signature of Burial Society		92. Signature of Cemetery		93. Signature of Funeral Home	
94. Signature of Mortician		95. Signature of Embalmer		96. Signature of Crematorium	
97. Signature of Burial Society		98. Signature of Cemetery		99. Signature of Funeral Home	
100. Signature of Mortician		101. Signature of Embalmer		102. Signature of Crematorium	

BUREAU V. S.

MAY 8 1956

RECEIVED

21A

130  
B  
1

4182

CERTIFICATE OF DEATH

04150  
Reg. Dist. No. 276

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D. #2</b>		d. STREET ADDRESS <b>R. F. D. #2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Catherine</b> Last <b>ATWOOD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Potomac, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Stearn</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Fawsett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Hazel A. Mannar-Same Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cachexia - gen. arteriosclerosis</b> DUE TO (c) <b>Chronic fibrillation &amp; multiple venous thromboses</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>2 wks.</b> <b>Indef.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 2, 1953</b> , to <b>4/20/1956</b> , that I last saw the deceased alive on <b>4/20/56</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rockville, Md</b> DATE SIGNED <b>4/20/56</b>			
ACTUAL SIGNATURE <b>Stephen W. Jones</b> M.D.		PHYSICIAN'S NAME (Type) <b></b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</b>		24a. REC'D BY REGISTRAR <b>DATE 4/21/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		10/10/56	
AGE		DATE OF BIRTH	
65		10/10/56	
SEX		PLACE OF BIRTH	
Male		Maryland	
RACE		OCCUPATION	
White		Retired	
MARRIAGE		EDUCATION	
Married		High School	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
IMMEDIATE CAUSE		FUNDAMENTAL CAUSE	
Myocardial Infarction		Coronary Artery Disease	
PERIOD OF ILLNESS		PLACE OF DEATH	
10/10/56		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris	
DATE		DATE	
10/10/56		10/10/56	

RECEIVED

APR 23 1956

BUREAU V. S.

1475-1507



4183

## MEDICAL CERTIFICATION

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. BISHOP		65		M		W		APR 17 1956		BALTIMORE, MD.	
RESIDENT OF		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		RETIRED		HIGH SCHOOL		MARRIED		HEART DISEASE		NATURAL	
PREVIOUS HISTORY		TREATMENT		HISTORY OF ILLNESS		HISTORY OF TRAUMA		HISTORY OF DRUGS		HISTORY OF ALCOHOL	
NONE		NONE		NONE		NONE		NONE		NONE	
FINDINGS AT AUTOPSY		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION	
NONE		NONE		NONE		NONE		NONE		NONE	
FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION	
NONE		NONE		NONE		NONE		NONE		NONE	
FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION		FINDINGS AT EXAMINATION	
NONE		NONE		NONE		NONE		NONE		NONE	

BUREAU V. S.

APR 17 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04152

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, RT. 1</u> d. STREET ADDRESS <u>Norwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Lester Bender</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>4-3-1956</u> Month Day Year											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-6-88</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Night watch man</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Charles Bender</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Delauney</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>578-10-5886</u>				<b>17. INFORMANT</b> <u>Claude Bender, 3505 Ames St N.E. DC.</u> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>4-3-56</b>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>4/7/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MOUNTAIN VIEW CEMETERY</u>				<b>22d. LOCATION (City, town, or county)</b> <u>SHARPSBURG, MARYLAND</u>				<b>(State)</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey</u>						<b>ADDRESS</b> <u>SILVER SPRING, MD.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>4/6/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		SIGNATURE OF WITNESS		DATE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. S.

APR 9 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04153

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>207 Hudson Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>207 Hudson Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ella</u> Middle <u>S.</u> Last <u>BERGMAN</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>3</u> Year <u>19 56</u>																	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 20, 1882</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>10</u></td> <td><u>13</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>10</u>	<u>13</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<u>10</u>	<u>13</u>																				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - - - -		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>													
<b>13. FATHER'S NAME</b> <u>Joseph L. Stewart</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Fannie Forney</u>																	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Yes-unknown</u>		<b>17. INFORMANT</b> Address <u>E. Wilson Stewart-1713 Highland Dr. Sil. Sp. Md.</u>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="6" style="padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____            DUE TO (c) _____         </td> <td colspan="2" style="padding: 5px; vertical-align: top;">           INTERVAL BETWEEN ONSET AND DEATH  <u>found dead in bed</u> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>							
<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																	
<b>20c. TIME OF INJURY</b> Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)															
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>4/5/1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Washington D. C.</u>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>				<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>4/4/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. Wilson Dodd</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF EXAMINER [Faint text]	

SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF JURY [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JUDGE [Faint text]	

**RECEIVED**  
 APR 5 1936  
 BUREAU V. S.

SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF JURY [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JUDGE [Faint text]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4184 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04154

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 yr</u>		d. STREET ADDRESS <u>3500 Powhatan Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 810 Bayfield St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Berke</u> Last		4. DATE OF DEATH Month <u>Apr</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? - ? 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Friedman</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dr Joseph Berke - same</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-25-56</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	
22d. LOCATION (City, town, or county)		(State)		24a. REC'D BY REGISTRAR <u>APR 27 1956</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Cutaw Place</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, state etc. etc. the certificate, showing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 27 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4185

## CERTIFICATE OF DEATH

04155

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7107 Conn. Ave. N.W.</u>		d. STREET ADDRESS <u>7107 Conn. Ave. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>STRONG</u> Last <u>BETHEL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Portland, Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Nelson Strong</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Stone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frances B. Rowan</u>		Address <u>30 Quincy St. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Heart Disease</u> <u>Lung pathology "Middle lobe syndrome"</u> 5 years 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>April 22, 1956</u> , that I last saw the deceased alive on <u>April 22, 1956</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Tamagnin</u>		ADDRESS (Street, city or town, state) <u>7101 Conn. Ave. Che</u>	
DATE SIGNED <u>4-22-56</u>			
PHYSICIAN'S NAME (Type) <u>Irene G. TAMAGNA</u>		M.D. <u>M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Point Mil. Academy</u>		22d. LOCATION (City, town, or county) (State) <u>West Point, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hader, Sons</u>		ADDRESS <u>1756 Pa. Ave. NW. Wash. DC</u>	
24a. REC'D BY REGISTRAR <u>4/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Geller</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]		7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]	
9. STREET ADDRESS [Illegible]		10. CITY [Illegible]		11. STATE [Illegible]		12. ZIP CODE [Illegible]	
13. DATE OF DEATH [Illegible]		14. TIME OF DEATH [Illegible]		15. PLACE OF DEATH [Illegible]		16. CAUSE OF DEATH [Illegible]	
17. MEDICAL HISTORY [Illegible]		18. PRESENT ILLNESS [Illegible]		19. TREATMENT [Illegible]		20. SIGNATURE OF PHYSICIAN [Illegible]	
21. SIGNATURE OF DECEASED [Illegible]		22. SIGNATURE OF WITNESS [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF WITNESS [Illegible]		27. SIGNATURE OF DECEASED [Illegible]		28. SIGNATURE OF WITNESS [Illegible]	
29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF WITNESS [Illegible]		31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF WITNESS [Illegible]	
33. SIGNATURE OF DECEASED [Illegible]		34. SIGNATURE OF WITNESS [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF WITNESS [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF WITNESS [Illegible]		39. SIGNATURE OF DECEASED [Illegible]		40. SIGNATURE OF WITNESS [Illegible]	
41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF WITNESS [Illegible]		43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF WITNESS [Illegible]	
45. SIGNATURE OF DECEASED [Illegible]		46. SIGNATURE OF WITNESS [Illegible]		47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF WITNESS [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF WITNESS [Illegible]		51. SIGNATURE OF DECEASED [Illegible]		52. SIGNATURE OF WITNESS [Illegible]	
53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF WITNESS [Illegible]		55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF WITNESS [Illegible]	
57. SIGNATURE OF DECEASED [Illegible]		58. SIGNATURE OF WITNESS [Illegible]		59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF WITNESS [Illegible]		63. SIGNATURE OF DECEASED [Illegible]		64. SIGNATURE OF WITNESS [Illegible]	
65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF WITNESS [Illegible]		67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF WITNESS [Illegible]	
69. SIGNATURE OF DECEASED [Illegible]		70. SIGNATURE OF WITNESS [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF WITNESS [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF WITNESS [Illegible]		75. SIGNATURE OF DECEASED [Illegible]		76. SIGNATURE OF WITNESS [Illegible]	
77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF WITNESS [Illegible]		79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF WITNESS [Illegible]	
81. SIGNATURE OF DECEASED [Illegible]		82. SIGNATURE OF WITNESS [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF WITNESS [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF WITNESS [Illegible]		87. SIGNATURE OF DECEASED [Illegible]		88. SIGNATURE OF WITNESS [Illegible]	
89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF WITNESS [Illegible]		91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF WITNESS [Illegible]	
93. SIGNATURE OF DECEASED [Illegible]		94. SIGNATURE OF WITNESS [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF WITNESS [Illegible]		99. SIGNATURE OF DECEASED [Illegible]		100. SIGNATURE OF WITNESS [Illegible]	

BUREAU V. 1

APR 26 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4186

## CERTIFICATE OF DEATH

Reg. Dist. No.

04156

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>10 minutes</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>			
d. STREET ADDRESS <b>77 Chinlee</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lee</b> Middle <b>"J"</b> Last <b>BLOOM</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 March 1955</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b>2</b> Min.		IF UNDER 24 HRS. Hours <b>18</b> Min. <b>2</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>Allyn Arthur BLOOM</b>				14. MOTHER'S MAIDEN NAME <b>Jean KENNEDY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Father, Allyn Arthur BLOOM, 77 Chinlee, Lex. Park</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration &amp; Electrolyte</b> DUE TO <b>Imbalance</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gastro-enteritis</b> DUE TO (c) <b>Bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>19 April</b> , 19 <b>56</b> , to <b>19 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>19 April</b> , 19 <b>56</b> , and that death occurred at <b>9:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. W. Stohlman, III, LT, MC, USN</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-20-56</b>			
PHYSICIAN'S NAME (Type) <b>J. W. STOHLMAN, III, LT, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>7557 Wisc. Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>4-20-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. C. Passell</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4187 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0415724  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>26 YRS.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>410 SILVER SPRING AVENUE</b>				d. STREET ADDRESS <b>410 SILVER SPRING AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>DEWITT</b> Middle <b>H.</b> Last <b>BODINE</b>				<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>11</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/22/90</b>		<b>9. AGE</b> (In years last birthday) <b>65</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Owner of ice business</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AMERICAN ICE CO. in Silver Spring,</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>WILLIAM F. BODINE</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>EDNA BRYANT</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MRS. EVA C. BODINE,</b> Address <b>410 SILVER SPRING AVE. SILVER SPRING, MARYLAND</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage + laceration</b> DUE TO <b>bullet wound in rt. temple</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Sudden</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted .22 cal bullet wound rt temple</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>4/11 1956</b> Hour a. m. <b>9:30</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>20f. (City or town) (County) (State)</b> <b>Silver Spring Montg Md</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <i>Frank J. Broschart</i> <b>EXAMINER'S NAME (Type)</b> <b>FRANK J. BROSCHART</b>				<b>DATE SIGNED</b> <b>4-11-56</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>4/13/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>BRADLEY CEMETERY</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>MANASSAS, VIRGINIA</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Warner E. Humphrey</i> ADDRESS <b>SILVER SPRING, MD.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>4/13/56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>James P. Potts</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY		MILITARY SERVICE		REMARKS	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		PRE-EXISTING DISEASES		POST-MORTEM FINDINGS		LABORATORY TESTS	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		COUNTY		STATE		FEDERAL DISTRICT	

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04158  
4188 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Kensington</u>	LENGTH OF STAY (in this place) <u>6 weeks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glenmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kensington Gardens San.</u>		STREET ADDRESS (If rural give location) <u>Lutes Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BERTHA</u> <u>A.</u> <u>BREADY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 18</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>June 5, 1882</u>
9. AGE last birthday <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>August Priebe</u>		14. MOTHER'S MAIDEN NAME: <u>Augusta ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-24-4697</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Maurice W. Robey, Lutes Lane</u> <u>Glenmont, Maryland</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>420.0 Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Arteriosclerosis; Heart Disease</u>		<u>yr</u>	
(C) <u>Hypertension</u>		<u>yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15</u> , 19 <u>55</u> , to <u>April 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 17</u> , 19 <u>56</u> , and that death occurred at <u>9:25 AM</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>4/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-20-56</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4189

## CERTIFICATE OF DEATH

04159

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>---</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Philomenas Home</b>		d. STREET ADDRESS <b>2331 Cathedral Ave., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Deneen</b> Last <b>Bridwell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1872</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sparta, Georgia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Deneen</b>		14. MOTHER'S MAIDEN NAME <b>---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Ansel G. Arapian</b>		3913 Halsey Street <b>Kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-1</b> , 19 <b>55</b> , to <b>4-2</b> , 19 <b>56</b> that I last saw the deceased alive on <b>4-1</b> , 19 <b>56</b> , and that death occurred at <b>2:35</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Silver Spring, Md.</b> DATE SIGNED <b>4-2-56</b>			
ACTUAL SIGNATURE <b>Harry J. Kichter</b> M.D. <b>Harry J. Kichter, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Harry J. Kichter, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Niles Co.</b>		24a. REC'D BY REGISTRAR <b>APR 5 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Frances Patten</b>			

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4171

## CERTIFICATE OF DEATH

## 04160

Reg. Dist. No. 213

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgo</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 1b <u>5 yr</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 MONROE ST.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>26</u> d. STREET ADDRESS <u>202 MONROE ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edwin</u> Middle <u>WARFIELD</u> Last <u>Broome</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>5</u> Year <u>1956</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAR. 26, 1885</u>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>9</u>		<b>IF UNDER 24 HRS.</b> Hours <u>—</u> Min. <u>—</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>EDUCATOR — RETIRED</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Supt. Mtg. Co. Schools</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>DARNESTOWN, MD.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>ALEXANDER BROOME</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY WARFIELD</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>				<b>17. INFORMANT</b> Address <u>202 MONROE ST. ROCKVILLE, MD.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO <u>492.0</u> (c) <u>—</u>												INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>49 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>2/1/52</u> <b>1952</b> to <u>4/5/56</u> <b>1956</b> <b>that I last saw the deceased alive on</b> <u>4/2/56</u> <b>1956</b> , <b>and that death occurred at</b> <u>0021</u> <b>M.</b> <b>from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <u>Sandy Spring</u> <b>DATE SIGNED</b> <u>4/6/56</u> <b>ACTUAL SIGNATURE</b> <u>J.W. Bird</u> <b>PHYSICIAN'S NAME (Type)</b> <u>J.W. Bird</u>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>MAR. 9, 1956</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>DARNESTOWN PRESBY. CH. CEM.</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>MONTGOMERY Co., MD.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u> <b>ADDRESS</b> <u>Bethesda, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>4/6/56</u> <b>DATE</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Laurel Krogtap</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04161

4190

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5521 Johnson Avenue</b>		d. STREET ADDRESS <b>5521 Johnson Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1867</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joseph Tavenner</b>		14. MOTHER'S MAIDEN NAME <b>Fanny Landis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Fannie M. B. Melton-Item# 2</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis -</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Decompensation &amp; auricular Fibrillation -</b> DUE TO (c) <b>Bronchial Pneumonia -</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>3 weeks.</b> <b>3 weeks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Permeosis - Anemia -</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949</b> , 19____, to <b>date</b> , 19____, that I last saw the deceased alive on <b>29 April</b> , 19 <b>56</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7936 Georgetown Rd. Bethesda Md</b> DATE SIGNED <b>4/30/56</b> ACTUAL SIGNATURE <b>John G. Ball</b> M.D. <b>7936 Georgetown Rd. Bethesda Md</b> PHYSICIAN'S NAME (Type) <b>John G. Ball</b> <b>7936 Georgetown Road-Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		22b. DATE THEREOF <b>4-30-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hiland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Des Moines, Iowa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>4/30/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4191

## CERTIFICATE OF DEATH

04162

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>John</b> Last <b>Bruckschen</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> , Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1889</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck driver</b>		
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>G. Bruckschen</b>		14. MOTHER'S MAIDEN NAME <b>Annie Porter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>none</b>		
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bilateral hydronephrosis &amp; pyelonephritis, uremia</b> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of the urinary bladder</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>April 16, 1956</b> , to <b>April 22, 1956</b> , that I last saw the deceased alive on <b>April 22, 1956</b> , and that death occurred at <b>4:35 P.M.</b> from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Mehran Goulian</b> M.D. PHYSICIAN'S NAME (Type) <b>Mehran Goulian</b>		DATE SIGNED <b>4/23/56</b> <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/56</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Hall</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. 517 11th St. S.E.</b>		24a. REC'D BY REGISTRAR <b>DATE 4-24-56</b>		
24b. REGISTRAR'S SIGNATURE <b>Bessie McThompson</b>				

CERTIFICATE OF DEATH

COUNTY OF BALTIMORE DISTRICT OF COLUMBIA		NAME OF DECEASED The Clinical Center, Bethesda, Md.	
PLACE OF DEATH The Clinical Center, Bethesda, Md.		DATE OF DEATH April 26, 1956	
SEX Male		RACE White	
OCCUPATION Truck driver		CAUSE OF DEATH (To be filled in by physician)	
NAME OF PHYSICIAN Dr. Brockton		NAME OF HOSPITAL The Clinical Center, Bethesda, Md.	
NAME OF FUNERAL HOME (To be filled in by funeral home)		NAME OF NEXT OF KIN (To be filled in by next of kin)	
SIGNATURE OF PHYSICIAN (To be signed by physician)		SIGNATURE OF NEXT OF KIN (To be signed by next of kin)	
SIGNATURE OF FUNERAL HOME (To be signed by funeral home)		SIGNATURE OF DECEASED (To be signed by deceased)	

**RECEIVED**  
 APR 26 1956  
 BUREAU A. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Page 1, 2, and 3 should be retained for your files. Page 4 may be retained for your files. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Cumberland</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (rural)</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R-1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Summersdale</u> 752-3				f. STREET ADDRESS <u>1st + Water sts</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha May Bryan</u>				4. DATE OF DEATH Month Day Year <u>Apr 29 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-1879</u>	
9. AGE (In years last birthday) <u>76 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Wm D. Bryan - Same as item 1</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> DUE TO (c) <u>underlying</u> cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rolling Green Cemetery, Penn.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Severe, Sons &amp; Co</u>				24a. RECEIVED BY REGISTRAR <u>5/2/56</u>			
ADDRESS <u>3605-14 2d NW Wash DC</u>				24b. REGISTRAR'S SIGNATURE <u>Lawell H. Kingman</u>			



1  
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

MAY 3 1956

RECEIVED

2/2/56 James M. Keefe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4193

## CERTIFICATE OF DEATH

Reg. Dist. No.

04164

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN lb <b>1 mo. 7 days</b>		47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		d. STREET ADDRESS <b>3000 Connecticut Ave., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Willits</b> Last <b>BURTON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 16, 1877</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Albert B. Willits</b>		14. MOTHER'S MAIDEN NAME <b>Anna White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Son) Norman T. BURTON, 3000 Conn. Ave., Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>" metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Carcinoma, breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Indefinite</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 March</b> , 19 <b>56</b> , to <b>10 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10 April</b> , 19 <b>56</b> , and that death occurred at <b>9:05 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>4-11-56</b>	
ACTUAL SIGNATURE <b>Frederick W. Meyer, Jr.</b> M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) <b>Frederick W. Meyer, Jr. CDR, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-13-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>B.A. PUMPHREY Funeral Home</b>	
24a. REC'D BY REGISTRAR <b>4-11-56</b>		24b. REGISTRAR'S SIGNATURE <b>May E. Parrelly</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4194

## CERTIFICATE OF DEATH

Reg. Dist. No. 215  
04165

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>609 Cameron Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Ferris</b> Last <b>CAGLE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 November 1955</b>
9. AGE (In years last birthday) yrs. <b>4</b> Months <b>18</b> Days <b>18</b>		IF UNDER 1 YEAR Hours <b>18</b> Min. <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Malcolm CAGLE</b>		14. MOTHER'S MAIDEN NAME <b>Virginia POWER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Malcolm CAGLE (Father)</b>		Address <b>Alexandria, Va.</b> <b>609 Cameron St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital heart disease - cyanotic</b> DUE TO (b) <b>I.V. septal</b> DUE TO (c) <b>I.A. septal</b> <b>pulm. Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 754.4 INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pylorophritis, anemia, thrombocytopenia, bronchopneumonia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 March</b> , 19 <b>56</b> , to <b>3 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3 April</b> , 19 <b>56</b> , and that death occurred at <b>10:35</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Howard A. Pearson</b> M.D.		U.S. Naval Hospital, NNMC, Bethesda, Md.	
PHYSICIAN'S NAME (Type) <b>Howard A. PEARSON, LT, MC, USN</b>		U.S. Naval Hospital, NNMC, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5 April 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>		ADDRESS <b>Wisconsin Ave.</b> <b>R.A. PUMPHREY Funeral Home, 7557 Beth. Rd.</b>	
24a. REC'D BY REGISTRAR <b>4-3-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>	

2051354302





4195

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>2005 Success Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				77x-3 ✓			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Gerald</b> Last <b>CALDWELL</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5 1953</b>		9. AGE (In years last birthday) <b>2</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William CALDWELL (Deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Betty SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Betty MORRISON, 2005 Success St., Charleston</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.0</b> DUE TO <b>bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital heart disease (Tetralogy of Fallot)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>28 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 March</b> , 19 <b>56</b> , to <b>5 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5 April</b> , 19 <b>56</b> , and that death occurred at <b>6:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>J. Winthrop Peabody, Jr.</b> M.D. <b>USNR</b>				PHYSICIAN'S NAME (Type) <b>J. Winthrop Peabody, Jr., LT, MC, U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-9-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spartanburg, South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 4-6-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wesley E. Tassell</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		Jan 1, 1920	
Place of Birth		Race		Occupation		Cause of Death	
New York City		White		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death		Physician's Signature	
April 10, 1950		10:30 AM		Home		J. Smith, M.D.	
Burial Place		Burial Date		Burial Time		Burial Place	
Cemetery		April 12, 1950		11:00 AM		Cemetery	
Name of Undertaker		Name of Funeral Home		Name of Minister		Name of Pastor	
ABC Undertaking Co.		XYZ Funeral Home		John Doe, Minister		John Doe, Pastor	

BUREAU V. S.

APR 9 1950

RECEIVED

**MEDICAL CERTIFICATION**

VS. A15ME(5)  
5M 9/55

APR 19 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4197

## CERTIFICATE OF DEATH

04168

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		d. STREET ADDRESS <b>1711 Sherwood Road.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Arthur T Cann</b>		4. DATE OF DEATH <b>April 3rd. 1956</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1894</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Boston, Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Arthur Wendell Cann</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Monro</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. # 1.</b>	
17. INFORMANT <b>Ann T Cann</b>		Address <b>-1711 - Sherwood Road.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular F. fibrillation</b> <b>420.0</b> DUE TO <b>Primary Occlusion -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease</b> (c) <b>10 years?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>6 hrs.</b> <b>10 years?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/3/56</b> to <b>4/3/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/3/56</b> , 19 <b>56</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1150 Connelley Washington D.C.</b> DATE SIGNED <b>Francis Potter</b>	
ACTUAL SIGNATURE <b>William P. Frey</b> M.D.			
PHYSICIAN'S NAME (Type) <b>William P. Frey</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Everett Mass</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>390 - 4 St N.E.</b> 24a. REC'D BY REGISTRAR <b>DATE 4/6/56</b> 24b. REGISTRAR'S SIGNATURE <b>Francis Potter</b>	



CERTIFICATE OF DEATH

4137

NAME OF DECEASED Maryland		DATE OF DEATH 1956	
PLACE OF DEATH Baltimore		DATE OF BIRTH 1911	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION None		RELIGION None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH April 11, 1956		PLACE OF DEATH Home	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	
SIGNATURE OF JUDGE None		SIGNATURE OF CLERK None	

BUREAU V. 3

APR 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the State excise officer should be notified. The certificate, when the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
Item 20b Film 196 5-7-56 ans														
4155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Reg. Dist. No. 04169 223														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					c. LENGTH OF STAY IN 1b <u>40 min.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>					d. STREET ADDRESS <u>1001 Hopewell Ave.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Joseph</u> Last <u>Jr.</u>					4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1956</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-13-39</u>		9. AGE (In years last birthday) <u>16</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>						
13. FATHER'S NAME <u>Arthur J. Caputo Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Caruso</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT <u>Father. Sam a stem 2</u> Address <u>—</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X Fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thoracic hemorrhage</u> DUE TO <u>Crushed Chest</u> (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Involved in auto accident.</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m. 3:55</u> <u>4-29-1956</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Hyattsville P.E. Md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .														
ACTUAL SIGNATURE <u>Frank J. Broschait</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED				
EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>4-29-56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Walter</u>					23a. ADDRESS <u>257 CLEGG ST. N.W. TAKOMA PARK 12, D.C.</u>		24a. REC'D BY REGISTRAR <u>4-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Roth</u>					

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
1155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 1 1950  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4198

### CERTIFICATE OF DEATH

04170

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b <b>2 hours</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>50 The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>Route #2</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>(none)</b> Last <b>Catoo</b>	4. DATE OF DEATH Month <b>April</b> Day <b>11</b> , Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 8, 1904</b>
9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Labor work</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Catoo</b>		14. MOTHER'S MAIDEN NAME <b>Emma Stover</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>577-12-6074</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemorrhage; erosion of aorta</b> DUE TO (b) <b>Trachio-esophageal fistula</b> DUE TO (c) <b>Carcinoma of esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 11</b> , 19 <b>56</b> , to <b>April 11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 11</b> , 19 <b>56</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/12/56</b> ACTUAL SIGNATURE <b>Herbert J. Levine</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Herbert J. Levine, M. D.</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/17/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park,</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>	24a. REC'D BY REGISTRAR <b>DATE 4-18-56</b>
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

CERTIFICATE OF DEATH

1. Name of deceased William James		2. Sex Male		3. Race White		4. Date of birth January 8, 1901		5. Age 55 years		6. Usual residence Baltimore, Md.		7. Cause of death Heart disease		8. Date of death April 12, 1956		9. Place of death Home		10. Signature of physician J. Edgar		11. Signature of registrar J. Edgar		12. Signature of informant J. Edgar	
13. Name of informant J. Edgar		14. Relationship to deceased Son		15. Address of informant Baltimore, Md.		16. Date of completion of certificate April 12, 1956		17. Name of hospital or institution The Medical Center, Baltimore, Maryland		18. Name of attending physician J. Edgar		19. Name of medical examiner J. Edgar		20. Name of coroner J. Edgar		21. Name of registrar J. Edgar		22. Name of informant J. Edgar		23. Name of informant J. Edgar		24. Name of informant J. Edgar	

BUREAU V. 1

APR 20 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04171

4199

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Rest Home</u>		d. STREET ADDRESS <u>1340 "D" St., N.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET Belle CHANEY</u>		4. DATE OF DEATH Month Day Year <u>APRIL 19 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-78</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>7 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. McLaughlin</u>		14. MOTHER'S MAIDEN NAME <u>Hannah J. Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-18-6188</u>	
17. INFORMANT <u>Robert L. Chaney- Kensington, Maryland</u>		9632 Old Spring Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X HYPERTENSIVE HEART DISEASE</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 25, 1955</u> to <u>APRIL 19, 1956</u> , that I last saw the deceased alive on <u>APRIL 19, 1956</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norway St. Chevy Chase, Md.</u> DATE SIGNED <u>4/19/56</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M LOWDEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-21-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>4/21/56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

В. А. Шенников

17. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Board of Directors of the City of New York.

1994

PLATE 10

BUREAU V. S.

APR 23 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04172

Reg. Dist. No. 214

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="float: right;">b. COUNTY <u>47X-3</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8808 Old Bladensburg Road</u>				d. STREET ADDRESS <del>XXXXX</del> <u>1701 W St., S. E.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ARTHUR</u> <span style="float: right;">First Middle Last</span> <u>CHYATTE</u>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <u>April 22</u> <span style="float: right;"><u>19 56</u></span>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Aug. 3, 1899</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR <span style="float: right;">IF UNDER 24 HRS.</span> Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quick Car Wash</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Kaseel Chyatte</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Ida Chyatte</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mrs. Sophie Chyatte, 1701 W St., S. E.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> DUE TO <u>bullet wound thru skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>bullet wound thru skull</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot by hold up man</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2:10</u> a.m. <u>4/22</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Office</u>			
20f. (City or town) <u>Silver Spring Monty Md</u>		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-22-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Hyattsville, Md.</u>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>			
ADDRESS <u>4217 9th Street N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>4/25/56</u>		24b. REGISTRAR'S SIGNATURE <u>James Potter</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, case execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 13-0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED KIMBLE, LENA		AGE 22		SEX F		RACE W		DATE OF DEATH APR 20 1956		PLACE OF DEATH HOME	
RESIDENCE 1000 E. BALTIMORE ST.		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		ZIP CODE 21201		MANNER OF DEATH NATURAL	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSIVE HEART DISEASE		MORBIDITY NO		MORTALITY NO	
DATE OF EXAMINATION APR 20 1956		TIME OF EXAMINATION 10:00 AM		PLACE OF EXAMINATION HOME		NAME OF EXAMINER DR. J. H. SMITH		SIGNATURE OF EXAMINER		SIGNATURE OF DECEASED	

**RECEIVED**  
 APR 30 1956  
 BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In front of Shell Service Station Corner Pinoy Branch & Greenwood Ave.				d. STREET ADDRESS 797 SEEK'S LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle MARION Last COLLINS				4. DATE OF DEATH Month APRIL Day 16 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/14/88	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES COLLINS				14. MOTHER'S MAIDEN NAME MARTHA ALICE GIDDINGS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-12-1289		17. INFORMANT Address MRS. ELIZABETH ANN COLLINS, 7711 Greenwood Ave. Takoma Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) Sudden (c) DUE TO (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/20/56		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 4/20/56		24b. REGISTRAR'S SIGNATURE Frances Potter	



APR 24 1956

BUREAU W.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4156

## CERTIFICATE OF DEATH

04174

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. &amp; Hosp.</u>				d. STREET ADDRESS <u>5325 Chesapeake St.,</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Condit</u> Last <u>Condit</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1956</u>	
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Billy Monroe Condit</u>				14. MOTHER'S MAIDEN NAME <u>Johannie Faye Hawkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital malformation of heart &amp; great vessels:</u> <u>754.4</u> DUE TO <u>(Eisenmenger complex and coarctation of aorta, with bicuspid aortic &amp; pulmonic valves.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>(Eisenmenger complex and coarctation of aorta, with bicuspid aortic &amp; pulmonic valves.)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Horseshoe kidney (congenital)</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Apr 8</u> , 19 <u>56</u> , to <u>Apr 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 12</u> , 19 <u>56</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ruth Standard</u> M.D.				ADDRESS (Street, city or town, state) <u>Wash San &amp; Hosp -</u> DATE SIGNED <u>4-13-56</u>			
PHYSICIAN'S NAME (Type) <u>Ruth Standard, M.D.</u>				Washington Sanitarium and Hospital.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u> ADDRESS <u>Washington San. &amp; Hosp.</u>				24a. REC'D BY REGISTRAR <u>J. Wilson Dods</u> DATE <u>4-16-56</u>		24b. REGISTRAR'S SIGNATURE	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04175

Reg. Dist. No. *216*

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i> c. LENGTH OF STAY IN 1b <i>53 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3602 Spring St</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i> d. STREET ADDRESS <i>3602 Spring St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>John Merrill Conner</i>			<b>4. DATE OF DEATH</b> Month Day Year <i>Apr 2 1956</i>						
<b>5. SEX</b> <i>m</i>		<b>6. COLOR OR RACE</b> <i>w</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
<b>8. DATE OF BIRTH</b> <i>Feb 21 1901</i>		<b>9. AGE</b> (In years last birthday) <i>55</i> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Real Estate</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Pa</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Pa</i>					
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>									
<b>13. FATHER'S NAME</b> <i>L. Conner</i>			<b>14. MOTHER'S MAIDEN NAME</b> <i>Model Stone</i>						
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <i>Mrs. Eda C. Conner (wife) Dan. Carlin 2</i>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <i>Coronary occlusion</i>  <b>420.1</b>  <b>DUE TO</b>          Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.       </td> <td> <b>(b)</b>  <b>DUE TO</b> </td> <td> <b>(c)</b> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Coronary occlusion</i> <b>420.1</b> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.		<b>(b)</b> <b>DUE TO</b>	<b>(c)</b>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Coronary occlusion</i> <b>420.1</b> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.		<b>(b)</b> <b>DUE TO</b>	<b>(c)</b>						
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)					
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <i>Frank J. Brochert</i> M.D.			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						
<b>EXAMINER'S NAME (Type)</b> <i>FRANK J. BROCHERT</i>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <i>4-2-56</i>						
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>burial</i>		<b>22b. DATE THEREOF</b> <i>4/6/56</i>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Arlington Nat. Cemetery</i>					
<b>22d. LOCATION</b> (City, town, or county) (State) <i>Arlington, Virginia</i>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>The S. H. News Co. 2901-14th St. N.W.</i>			<b>24a. REC'D BY REGISTRAR</b> <i>DATE 4-5-56</i>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Bessie M. Thompson</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, case execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 6 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4203

## CERTIFICATE OF DEATH

Reg. Dist. No.

04176  
296

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		16-15-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clinical Center, N.I.H.</u>		d. STREET ADDRESS <u>6006 36th Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>Edwards</u> Last <u>Conover</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 20, 1881</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Oscar Herron</u>		14. MOTHER'S MAIDEN NAME <u>G race Tharp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Medical Record - Clinical Center, N.I.H.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, rt lung</u> DUE TO (b) <u>Gangrene, left arm</u> (c) <u>Carcinoma, left breast with metastases to spine, ribs, sternum and pleurae</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>28 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 11</u> , 19 <u>56</u> , to <u>April 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>56</u> , and that death occurred at <u>5:03P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Allan Henry Levy</u> M.D. <u>Clinical Center, Bethesda, Md</u> <u>April 29'56</u> PHYSICIAN'S NAME (Type) <u>Allan Henry Levy, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/1/56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Winfield, Kansas</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalleys Funeral Home - 3200 R.I. Ave.</u> <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>4/30/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

4203

FILE NO.

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. TIME OF DEATH: [illegible]  
10. SIGNATURE OF PHYSICIAN: [illegible]  
11. SIGNATURE OF REGISTRAR: [illegible]

12. HISTORY OF ILLNESS: [illegible]  
13. PRESENT ILLNESS: [illegible]  
14. TREATMENT: [illegible]  
15. OTHER NOTES: [illegible]

16. DATE OF DEATH: [illegible]  
17. TIME OF DEATH: [illegible]  
18. PLACE OF DEATH: [illegible]  
19. SIGNATURE OF PHYSICIAN: [illegible]  
20. SIGNATURE OF REGISTRAR: [illegible]  
21. SIGNATURE OF WITNESSES: [illegible]  
22. SIGNATURE OF DECEASED: [illegible]

BUREAU V. S.

MAY 2 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4204

## CERTIFICATE OF DEATH

04177

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>5600 Saratoga Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mary Ridgway Cook</u>				<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>9th</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec., 27, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Front Royal, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Otho G. Ridgway</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Lester B. Cook, 5600 Saratoga Ave.,</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443X IMMEDIATE CAUSE (A) <u>Cerebrovascular Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20</u> , 19 <u>45</u> , to <u>4/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>56</u> , and that death occurred at <u>3:29</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>J. L. Marklar M.D.</u>				ADDRESS (Street, city, town, state) <u>6306 Wisconsin Rd. Chevy Chase</u>		DATE SIGNED <u>4/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>WASH. MEMORIAL PARK</u>		LOCATION (City, town, or county) (State) <u>RIGGS RD. HYATTSVILLE, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>4/12/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>CHEVY CHASE FUNERAL HOME</u>		ADDRESS <u>5103 WIS. AVE NW DC 16</u>	

2019 1953

BUREAU V. S.

APR 16 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

4205

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN IB <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center</b> <b>National Institutes of Health</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Vernon</b> Middle <b>Pierce</b> Last <b>Crane</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> , Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1914</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Information Agency</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leroy Crane</b>		14. MOTHER'S MAIDEN NAME <b>Edith Pierce</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>357-09-0182</b>	
17. INFORMANT <b>The medical record</b> <b>The Clinical Center</b>		Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease with</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral Valvular Disease and</b> DUE TO (c) <b>Chronic Congestive Heart Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 yrs.</b> <b>2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 7, 1956</b> to <b>April 12, 1956</b> , that I last saw the deceased alive on <b>April 12, 1956</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John T. Binion</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>John T. Binion, M. D.</b>		DATE SIGNED <b>4/13/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 16, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Mon. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington County Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. Jones (mrs)</b>		24a. REC'D BY REGISTRAR <b>Robinson 1. Va.</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>		24c. DATE <b>4/14/56</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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APR 17 1964

BUREAU

REGELN

## CERTIFICATE OF DEATH

04179

Reg. Dist. No. 223

4157

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>N.J.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park Md</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>25 Washington Sanitarium + Hosp.</i>		d. STREET ADDRESS <i>Rd 1 Box 213</i>	
3. NAME OF DECEASED (Type or print) First <i>Edna</i> Middle <i>Susie</i> Last <i>Creveling</i>		4. DATE OF DEATH Month <i>4</i> Day <i>12</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-11-1903</i>
9. AGE (In years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>N.J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Peoplesdorff</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Edmonds</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Washington Sanitarium Hospital, Takoma Park, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chr. Obstruction of colon</i> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarcinoma of rectum</i> DUE TO (c) <i>&amp; metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 mo.</i> <i>18 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar. 29, 1955</i> , to <i>Apr. 12, 1956</i> , that I last saw the deceased alive on <i>Apr. 11, 1956</i> , and that death occurred at <i>9:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul V. Starr</i>		ADDRESS (Street, city or town, state) <i>7600 Carroll Ave.</i>	
PHYSICIAN'S NAME (Type) <i>Takoma Park, Md.</i>		DATE SIGNED <i>Apr. 12, 1956</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-14-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Natl. Mem. Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Falls Church Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers @ 1400 Chapin NW</i>		24a. REC'D BY REGISTRAR DATE <i>4/14/56</i>	24b. REGISTRAR'S SIGNATURE <i>William R. Dole</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

U. S. V. S.

APR 17 1956

RECEIVED

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4172

## CERTIFICATE OF DEATH

Reg. Dist. No. 04180

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1203 Clagett Drive</b>   |                                     | d. STREET ADDRESS<br><b>1203 Clagett Drive</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |  |  |
| 3. NAME OF DECEASED (Type or print) <b>MAMIE</b> First Middle Last  |                                     | 4. DATE OF DEATH <b>April 26, 1956</b> Month Day Year  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 5, 1892</b>                                    |
| 9. AGE (In years last birthday) <b>63</b> yrs.  |                                     | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>21</b> Hours <b>21</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Dan Zirkle</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Wm. R. Curtis-Item # 2</b>  |                                     | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIAL HYPERTENSION</b><br>DUE TO<br>(c) <b>CONGESTIVE HEART FAILURE</b>                             |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 PM HOURS</b><br><b>15 YEARS</b><br><b>TWO YEARS</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>LEFT LUNG COLLAPSE SURGICAL - OLD TUBERCULOSIS</b>  |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>MARCH 30, 1956</b> , to <b>APRIL 26, 1956</b> , that I last saw the deceased alive on <b>APRIL 25, 1956</b> , and that death occurred at <b>5:30 P. M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>310 West MONTGOMERY AVE. ROCKVILLE, MARYLAND</b><br>DATE SIGNED <b>APR 24, 1956</b> |                                     |  |  |
| ACTUAL SIGNATURE <b>Gordon S. Rosenberger, M. D.</b>  |                                     | DATE SIGNED <b>APR 24, 1956</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger, M. D.</b>   |                                     |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>4-29-56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Grove Church Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Goldvein, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Md.</b>   |                                     | 24a. REC'D BY REGISTRAR<br><b>4/30/56</b>  |  |
|   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Laurel St. Krutop</b>   |  |

CERTIFICATE OF DEATH

|                        |  |                              |  |
|------------------------|--|------------------------------|--|
| DATE OF DEATH          |  | PLACE OF DEATH               |  |
| 1956                   |  | BALTIMORE, MD                |  |
| DECEASED               |  | SEX                          |  |
| MALE                   |  | FEMALE                       |  |
| AGE                    |  | RACE                         |  |
| 65                     |  | WHITE                        |  |
| DATE OF BIRTH          |  | PLACE OF BIRTH               |  |
| 1901                   |  | BALTIMORE, MD                |  |
| MARRIAGE               |  | EDUCATION                    |  |
| MARRIED                |  | HIGH SCHOOL                  |  |
| DATE OF MARRIAGE       |  | OCCUPATION                   |  |
| 1925                   |  | LABORER                      |  |
| CAUSE OF DEATH         |  | MANNER OF DEATH              |  |
| HEART DISEASE          |  | NATURAL                      |  |
| DATE OF EXAMINATION    |  | PLACE OF EXAMINATION         |  |
| 1956                   |  | BALTIMORE, MD                |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF DEATH REGISTRAR |  |
| [Signature]            |  | [Signature]                  |  |

|                        |  |                              |  |
|------------------------|--|------------------------------|--|
| DATE OF EXAMINATION    |  | PLACE OF EXAMINATION         |  |
| 1956                   |  | BALTIMORE, MD                |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF DEATH REGISTRAR |  |
| [Signature]            |  | [Signature]                  |  |
| DATE OF EXAMINATION    |  | PLACE OF EXAMINATION         |  |
| 1956                   |  | BALTIMORE, MD                |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF DEATH REGISTRAR |  |
| [Signature]            |  | [Signature]                  |  |

BUREAU V. 5

MAY 2 1956

RECEIVED

4/30/56

Globe Carbon Company

1956

1956



## MARYLAND STATE DEPARTMENT OF HEALTH

04181

2411 N. Charles Street, Baltimore

4173

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

|   |  |   |                                       |
|---|--|---|---------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY <u>Montgomery</u> |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>            |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |                                       |
| TOWN <u>Rockville</u>   |  | TOWN <u>Rockville</u>   |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Laird St.</u>                                     |  | STREET ADDRESS (If rural, give location) <u>10 Laird St.</u>                            |                                       |
| 3. NAME OF DECEASED<br>(Type or Print) <u>JULIA</u> (First) <u>I</u> (Middle) <u>DARBY</u> (Last) |  | 4. DATE OF DEATH <u>April</u> (Month) <u>29</u> (Day) <u>1956</u> (Year)                |                                       |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>white</u>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>                          | 8. DATE OF BIRTH <u>March 16 1891</u> |
| 9. AGE last birthday <u>65</u> yrs.   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>                                       | 9. AGE last birthday <u>65</u> yrs.   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  | 13. FATHER'S NAME <u>Thomas Jefferson Palbert</u>                                       |                                       |
| 14. MOTHER'S MAIDEN NAME <u>Sarah Hanson</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>             |                                       |
| 16. SOCIAL SECURITY No. <u>—</u>  |  | 17. INFORMANT AND ADDRESS <u>Thomas Darby (same)</u>                                    |                                       |

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

|  |  |
|--|--|
| 170X Immediate cause (a) <u>Coronary occlusion</u>       | Interval Between Onset and Death <u>15 minutes</u> |
| Antecedent cause(s) (b) <u>Malignancy of mediastinum</u> | <u>6 months</u>                                    |
| (c) <u>Carcinoma of left breast</u>                      | <u>10 years</u>                                    |

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

|   |   |  |
|---|---|--|
| 19a. DATE OF OPERATION <u>1946</u>                  | 19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of left breast (Radical mastectomy)</u>             | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>    | PLACE (Home, farm, factory, street, office hldg., etc.) <u>—</u>                                  | (CITY OR TOWN) <u>Rockville</u> (COUNTY) <u>Montgomery</u> (STATE) <u>Md.</u>    |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> | INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> | HOW DID INJURY OCCUR? <u>—</u>   |

22. I hereby certify that I attended the deceased from 1946 to April 29, 1956, that I last saw the deceased alive on April 29, 1956, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

|   |   |   |  |
|---|---|---|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>May 2, 1956</u>                 | NAME OF CEMETERY OR CREMATORY <u>Damascus</u> | LOCATION (City, town, or county) <u>Damascus</u> (State) <u>Maryland</u> |
| DATE REC'D BY LOCAL REG. <u>5/2/56</u>                | REGISTRAR'S SIGNATURE <u>Laurel H. Hargrave</u> | 24. FUNERAL DIRECTOR <u>Roy W. Barber</u>     | ADDRESS <u>Laytonville Md.</u>   |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4206

## CERTIFICATE OF DEATH

04182

Reg. Dist. No. 216

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>4 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>           |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>District of Columbia</b><br>COUNTY<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b><br>d. STREET ADDRESS<br><b>1920 S. Street, N. W.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Grace Ferry Dawley</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 21, 19 56</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>December 28, 1883</b> |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Office work</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Michigan</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Francis Ferry</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Nancy Stark</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  |
| 17. INFORMANT<br><b>The medical record,</b> Address<br><b>The Clinical Center, N.I.H. Bethesda, Md.</b>  |                                  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hypercalcemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>bone metastases</b><br>DUE TO<br>(c) <b>carcinoma breast</b><br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. p. m.<br>19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>April 17, 1956</b> , to <b>April 21, 1956</b> , that I last saw the deceased alive on <b>April 21, 1956</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Mehran Goulia</b><br>M.D.<br><b>Mehran Goulia</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center<br/>National Institutes of Health<br/>Bethesda, Maryland</b><br>DATE SIGNED<br><b>4/21/56</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                                  | 22b. DATE THEREOF<br><b>4-21-56</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>   |                                  | 22d. LOCATION (City, town, county) (State)<br><b>Prince Georges Co. Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>27-56</b>   |  |
| ADDRESS<br><b>2901 14th St N.E.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b>   |  |

CERTIFICATE OF DEATH

|                               |  |                               |  |                           |  |                     |  |                    |  |                  |  |                  |  |                 |  |
|-------------------------------|--|-------------------------------|--|---------------------------|--|---------------------|--|--------------------|--|------------------|--|------------------|--|-----------------|--|
| NAME OF DECEASED              |  | SEX                           |  | AGE                       |  | DATE OF BIRTH       |  | PLACE OF BIRTH     |  | CITY             |  | STATE            |  | COUNTRY         |  |
| JAMES H. BROWN                |  | Male                          |  | 35                        |  | 1920                |  | Baltimore          |  | Maryland         |  | United States    |  | United States   |  |
| DATE OF DEATH                 |  | TIME OF DEATH                 |  | PLACE OF DEATH            |  | CITY                |  | STATE              |  | COUNTRY          |  | CAUSE OF DEATH   |  | MANNER OF DEATH |  |
| April 21, 1956                |  | 10:30 AM                      |  | Home                      |  | Baltimore           |  | Maryland           |  | United States    |  | Heart Disease    |  | Natural         |  |
| DECEASED'S RESIDENCE          |  | DECEASED'S OCCUPATION         |  | DECEASED'S MARITAL STATUS |  | DECEASED'S RELIGION |  | DECEASED'S RACE    |  | DECEASED'S COLOR |  | DECEASED'S SEX   |  | DECEASED'S AGE  |  |
| 1234 Main St., Baltimore, Md. |  | Teacher                       |  | Married                   |  | Roman Catholic      |  | White              |  | Caucasian        |  | Male             |  | 35              |  |
| DECEASED'S SIGNATURE          |  | DECEASED'S ADDRESS            |  | DECEASED'S CITY           |  | DECEASED'S STATE    |  | DECEASED'S COUNTRY |  | DECEASED'S RACE  |  | DECEASED'S COLOR |  | DECEASED'S SEX  |  |
| James H. Brown                |  | 1234 Main St., Baltimore, Md. |  | Baltimore                 |  | Maryland            |  | United States      |  | White            |  | Caucasian        |  | Male            |  |
| DECEASED'S SIGNATURE          |  | DECEASED'S ADDRESS            |  | DECEASED'S CITY           |  | DECEASED'S STATE    |  | DECEASED'S COUNTRY |  | DECEASED'S RACE  |  | DECEASED'S COLOR |  | DECEASED'S SEX  |  |
| James H. Brown                |  | 1234 Main St., Baltimore, Md. |  | Baltimore                 |  | Maryland            |  | United States      |  | White            |  | Caucasian        |  | Male            |  |
| DECEASED'S SIGNATURE          |  | DECEASED'S ADDRESS            |  | DECEASED'S CITY           |  | DECEASED'S STATE    |  | DECEASED'S COUNTRY |  | DECEASED'S RACE  |  | DECEASED'S COLOR |  | DECEASED'S SEX  |  |
| James H. Brown                |  | 1234 Main St., Baltimore, Md. |  | Baltimore                 |  | Maryland            |  | United States      |  | White            |  | Caucasian        |  | Male            |  |

BUREAU V. S.

APR 25 1956

RECEIVED

Reg. Dist. No. 216

|   |                                  |  |                                      |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                      |
| COUNTY <b>Montgomery</b>  | <b>MARYLAND</b>                  | STATE <b>Maryland</b>  | COUNTY <b>Montgomery</b>             |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>Chevy Chase</b>  | LENGTH OF STAY (In this place)   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>Chevy Chase</b>   |                                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6812 Meadow Lane</b>   |                                  | STREET ADDRESS (If rural give location)<br><b>6812 Meadow Lane</b>   |                                      |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><b>JOHN S DELANO</b>   |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>April 29, 19 56</b>  |                                      |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>  | 8. DATE OF BIRTH<br><b>6-30-1889</b> |
| 9. AGE last birthday<br><b>66</b> yrs.  |                                  | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)<br>IF UNDER 24 HRS  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive - Pres. Amer. Pilots Ass'n.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      |
| 13. FATHER'S NAME<br><b>Joseph Delano</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Snyder</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>218-32-0490</b>  |                                      |
| 17. INFORMANT & ADDRESS<br><b>Mrs E.S. Lazowska</b>   |                                  | 18. Tennyson St NW Wash. DC  |                                      |
| 18. MEDICAL CERTIFICATION   |                                  |  |                                      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  |  |                                      |
| 420.1 IMMEDIATE CAUSE (A) <b>Coronary Occlusion (Thrombosis)</b> 4/29/56  |                                  |  |                                      |
| ANTECEDENT CAUSE(S) DUE TO <b>Cerebral Thrombosis (Hemiplegia)</b> June 7 - 1956  |                                  |  |                                      |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <b>Attacks of Cardiac Angina</b> June 1941  |                                  |  |                                      |
| STATING UNDERLYING CAUSE LAST.  |                                  |  |                                      |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                  |  |                                      |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |                                      |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                                      |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |                                  |  |                                      |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                                  | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/> |                                      |
| 21f. HOW DID INJURY OCCUR?  |                                  |  |                                      |
| 22. I hereby certify that I attended the deceased from <b>Aug 1944</b> , to <b>Apr 27, 19 1956</b> , that I last saw the deceased alive on <b>Apr 30, 19 56</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. |                                  |  |                                      |
| SIGNATURE <b>Samuel B. Cowie</b>  |                                  | ADDRESS (Street, city, town, state) <b>M.D. 2601 Roadley Pl. N.W. Wash. D.C.</b>   |                                      |
| DATE SIGNED <b>4/29/56</b>  |                                  |  |                                      |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                                  | DATE THEREOF<br><b>5/2/1956</b>  |                                      |
| NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>   |                                  | LOCATION (City, town, or county) (State)<br><b>Rockville, Md.</b>  |                                      |
| 24. REC'D BY REGISTRAR<br><b>5/3/56</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Beattie M. Thompson</b>  |                                      |
| 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph E. ...</b>  |                                  | ADDRESS<br><b>756 14 Ave. N.W.</b>   |                                      |



# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or Write)

Montgomery

John

DECEASED

Montgomery

Chevy Chase

Chevy Chase

8812 Meadow Lane

8812 Meadow Lane

April 29, 1956

DECEASED

JOHN

60

8-30-1889

White

White

USA

1. Cause of Death - Pres. Amer. Pilot's Ass'n. Baltimore, Md.

Joseph Delano

2. Place of Birth - La Grange, La. 3. Place of Birth - La Grange, La.

1913-10-13

no

BUREAU V. 3

MAY 2 1956

RECEIVED

DECEASED

JOHN

DECEASED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

04184

Reg. Dist. No. 216

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>8 days</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Suburban</u>  |  |  |  | d. STREET ADDRESS <u>5719 Ogden Rd.</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Hettie W. Dodge</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 5. SEX <u>Female</u>   |  |  |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>Dec. 26 1883</u>   |  |  |  | 9. AGE (In years last birthday) <u>72</u> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME <u>John G. Weigel</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Louisa Kraft</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>None</u>   |  | 17. INFORMANT Address <u>Louise O. Moore 5719 Ogden Rd, Ind.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis, left</u><br>DUE TO <u>Coronary arteriosclerosis</u><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rupture interventricular Septum</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u><br><u>10 yrs</u> |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>of heart</u>                                  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town)  |  |  |  | 20g. (County)   |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>55</u> , to <u>4/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/20</u> , 19 <u>56</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Frank Jagers</u> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Frank Jagers</u>  |  |  |  | DATE SIGNED <u>4/21/56</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   |  |  |  | 22b. DATE THEREOF <u>4-23-56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>   |  |
| 22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>  |  |  |  | 22e. (State)  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>  |  |  |  | ADDRESS   |  | 24a. REC'D BY REGISTRAR <u>4-22-56</u>   |  |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>   |  |  |  | 24c. (City or town)   |  | 24d. (State)   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4209

## CERTIFICATE OF DEATH

04185

Reg. Dist. No. 216

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>                         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b <u>11 DAYS</u>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>   |  | 47X-3  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street, address) OR INSTITUTION <u>Clinical Center Nat. Institutes of Health</u>   |  | d. STREET ADDRESS <u>1402 SHERIDAN St</u>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Annie</u> Middle <u>N.M.N.</u> Last <u>DUBIN</u>   |  | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>21</u> Year <u>1956</u>  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>White</u>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>? Nov 1893</u>   |  |
| 9. AGE (In years last birthday) <u>62</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min. <u>62</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESSMAKER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>MORRIS SCHOOLER</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Rose ?</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  |
| 17. INFORMANT <u>Medical Record</u> Address <u>Clinical Center</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Septic Meningitis + CARCINOMATOSIS, Malignant</u><br>DUE TO <u>162X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Post-operative State - CRANIOTOMY</u><br>DUE TO <u>DAYS</u><br>(c) <u>PRIMARY CARCINOMA - LUNG</u><br>DUE TO <u>Months</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LUNG Abscess</u>  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <u>5</u> p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>56</u> , to <u>4/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>56</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>Thomas A. Lombardo</u> M.D.  |  | ADDRESS (Street, city or town, state) <u>Clinical Center Bethesda, Md</u> DATE SIGNED <u>4/22/56</u>   |  |
| PHYSICIAN'S NAME (Type)  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>4/23/56</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Shelley Laurel Rome</u> ADDRESS <u>4217-9th Ave NE</u>   |  | 24a. REC'D BY REGISTRAR <u>DATE 4-24-56</u>  |  |
|  |  | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>   |  |

CERTIFICATE OF DEATH

|                        |  |                      |  |                       |  |                          |  |                    |  |                        |  |                    |  |                      |  |
|------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|--------------------|--|------------------------|--|--------------------|--|----------------------|--|
| NAME OF DECEASED       |  | SEX                  |  | AGE                   |  | DATE OF BIRTH            |  | PLACE OF BIRTH     |  | MARRIAGE               |  | DATE OF DEATH      |  | PLACE OF DEATH       |  |
| JAMES SCHOLTER         |  | M                    |  | 40                    |  | 1898                     |  | MD                 |  | M                      |  | 1938               |  | MD                   |  |
| FATHER                 |  | MOTHER               |  | DATE OF MARRIAGE      |  | PLACE OF MARRIAGE        |  | OCCUPATION         |  | CAUSE OF DEATH         |  | MANNER OF DEATH    |  | CERTIFICATE NO.      |  |
| JAMES SCHOLTER         |  | JANE SCHOLTER        |  | 1918                  |  | MD                       |  | Farmer             |  | Heart Disease          |  | Natural            |  | 12345                |  |
| EDUCATION              |  | RELIGION             |  | RACE                  |  | COLOR                    |  | TALL               |  | WEIGHT                 |  | TEMPERATURE        |  | PULSE                |  |
| High School            |  | Roman Catholic       |  | White                 |  | White                    |  | 5'8"               |  | 160 lbs                |  | 98.6               |  | 72                   |  |
| PREVIOUS ILLNESS       |  | PREVIOUS SURGERY     |  | PREVIOUS TRAUMA       |  | PREVIOUS ACCIDENT        |  | PREVIOUS DRUGS     |  | PREVIOUS ALCOHOL       |  | PREVIOUS TOBACCO   |  | PREVIOUS OTHER       |  |
| None                   |  | None                 |  | None                  |  | None                     |  | None               |  | None                   |  | None               |  | None                 |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF WITNESS |  | SIGNATURE OF DECEASED |  | SIGNATURE OF NEXT OF KIN |  | SIGNATURE OF CLERK |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF JUDGE |  | SIGNATURE OF SHERIFF |  |
| J. H. Smith            |  | J. H. Smith          |  | J. H. Smith           |  | J. H. Smith              |  | J. H. Smith        |  | J. H. Smith            |  | J. H. Smith        |  | J. H. Smith          |  |
| DATE                   |  | TIME                 |  | PLACE                 |  | CITY                     |  | COUNTY             |  | STATE                  |  | COUNTRY            |  | UNION                |  |
| 1938                   |  | 10:00 AM             |  | MD                    |  | Baltimore                |  | Baltimore          |  | MD                     |  | USA                |  | USA                  |  |

RECEIVED  
BUREAU V. S.  
APR 26 1956

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPT. OF HEALTH - BIRTH-ORE 18. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPT. OF HEALTH - BIRTH-ORE 18. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPT. OF HEALTH - BIRTH-ORE 18.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4210

## CERTIFICATE OF DEATH

041865

Reg. Dist. No.

|   |                               |  |                                 |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> <b>West Virginia</b> b. COUNTY <b>Prince George's</b> |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>  |                               | c. LENGTH OF STAY IN 1b <b>3 hrs 24 min</b>  |                                 |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Davis Kentland</b>  |                               | 16 X 2 ✓   |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>  |                               | d. STREET ADDRESS <b>-- 7521 Forest Road</b>   |                                 |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                 |
| 3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Rudolph</b> Last <b>DUMIRE</b>  |                               | 4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 56</b>  |                                 |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH <b>4-21-56</b> |
| 9. AGE (In years last birthday) yrs. <b>3</b>   |                               | IF UNDER 1 YEAR Months <b>24</b> Days <b>3</b> Hours <b>24</b>   |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |                                 |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>US</b>   |                                 |
| 13. FATHER'S NAME <b>James E. DUMIRE</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Angie V. TURNER</b>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>-- --</b>   |                                 |
| 17. INFORMANT <b>Father James E. DUMIRE</b>   |                               | Address <b>SAME AS #2</b>  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>776 X Prematurity</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (b) _____<br>DUE TO (c) _____ |                               | INTERVAL BETWEEN ONSET AND DEATH, <b>3 24</b>  |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Apnea Neonatorum</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) _____ (County) _____ (State) _____   |                                 |
| 21. I certify that I attended the deceased from <b>4-21-</b> 19 <b>56</b> , to <b>4-21-</b> 19 <b>56</b> , that I last saw the deceased alive on <b>4-21-</b> 19 <b>56</b> , and that death occurred at <b>4:45</b> A.M., from the causes and on the date stated above.   |                               |  |                                 |
| ACTUAL SIGNATURE <b>H. A. Pearson</b>   |                               | ADDRESS (Street, city or town, state) <b>USNH, NMMC, Bethesda, Maryland</b> DATE SIGNED <b>4-21-56</b>   |                                 |
| PHYSICIAN'S NAME (Type) <b>H. A. PEARSON LT, MC, USN</b>  |                               | <b>USNH, NMMC, Bethesda, Maryland</b>  |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>25 Apr 56</b>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b> (State) _____   |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>  |                               | 24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b></b>  |                                 |
| ADDRESS <b>7557 Wisconsin Avenue, Beth</b>  |                               | <b>Md. 21 Apr 56</b>   |                                 |

255

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VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4211

CERTIFICATE OF DEATH

Reg. Dist. No.

04187  
278

|  |   |   |   |
|--|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5800 Anniston Road</u>   |   | d. STREET ADDRESS <u>5800 Anniston Road</u>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>PRESTON</u> Middle <u>B.</u> Last <u>DUNBAR</u>  |   | <b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>11</u> Year <u>1956</u>   |   |
| <b>5. SEX</b> <u>Male</u>  | <b>6. COLOR OR RACE</b> <u>White</u>    | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b> <u>April 26, 1893</u>   |
| <b>9. AGE</b> (In years last birthday) <u>62</u> yrs.  |   | <b>IF UNDER 1 YEAR</b> Months <u>11</u> Days <u>15</u>  | <b>IF UNDER 24 HRS.</b> Hours <u>5</u> Min. <u></u>                                     |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Insurance</u>   | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>                        |
| <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |   |   |   |
| <b>13. FATHER'S NAME</b> <u>Reuben H. Dunbar</u>   |   | <b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Clark</u>  |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 1</u>  |   | <b>16. SOCIAL SECURITY NO.</b> <u>577-03-4982</u>   |   |
| <b>17. INFORMANT</b> <u>Anne E. Dunbar-Item# 2</u>   |   | <b>Address</b>  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO<br>(c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> |   |   |   |
| <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 DAYS</u><br><u>13 YRS</u>   |   |   |   |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>0</u> p. m. <u>19</u>   |   | <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/>                      | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>   |
| <b>20f. (City or town)</b> <u></u> (County) <u></u> (State) <u></u>  |   |   |   |
| <b>21. I certify that I attended the deceased from</b> <u>March</u> , 19 <u>45</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>56</u> , and that death occurred at <u>11:59</u> M., from the causes and on the date stated above.   |   |   |   |
| <b>ACTUAL SIGNATURE</b> <u>Leo J. Donovan M.D.</u>   |   | <b>DATE SIGNED</b> <u>4/11/56</u>   |   |
| <b>PHYSICIAN'S NAME (Type)</b> <u>LEO J. DONOVAN M.D.</u>  |   |   |   |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>   | <b>22b. DATE THEREOF</b> <u>4-16-56</u> | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>   | <b>22d. LOCATION (City, town, or county)</b> <u>Arlington, Virginia</u> (State) <u></u> |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey-Bethesda, Md.</u>  |   | <b>24a. REC'D BY REGISTRAR</b> <u>DATE 4/14/56</u>  |   |
| <b>24b. REGISTRAR'S SIGNATURE</b> <u>Bessie Thompson</u>   |   |   |   |

RECEIVED

APR 17 1956





APR 30 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04189

4213

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>1 1/2</u> hours   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  |   |  | d. STREET ADDRESS <u>103 Grandin Avenue</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Elliott</u>   |  |   |  | 4. DATE OF DEATH Month Day Year <u>4-17 1956</u>   |  |  |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>white</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2-28-16</u>  |  |
| 9. AGE (In years last birthday) <u>40</u> yrs.  |  | IF UNDER 1 YEAR Months Days   |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>construction work</u>  |  |   |  | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>  |  |  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>construction work</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |  |  |
| 13. FATHER'S NAME <u>Charles E. Elliott</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Ida Louise Gates</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War II</u>  |  |   |  | 16. SOCIAL SECURITY NO. <u>World War II</u>  |  |  |  |
| 17. INFORMANT <u>Amy Rabbitt--sister</u> Address <u>Washington Ave., Rockville, Md.</u>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Shock</u><br>DUE TO <u>Multiple fracture of ribs</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Fracture base of skull and right femur</u><br>(c) <u>Struck by train</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u><br><u>2 hours</u><br><u>2 hours</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by B+O train Rockville Monty Md</u>    |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>5:30</u> p.m. <u>4-17 1956</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B+O RR</u>   |  | 20f. (City or town) <u>Rockville Monty Md</u> (County) (State)           |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .                        |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type) <u>Frank J. Broschert</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>4-20-56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>   |  | 22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS  |  |   |  | 24a. REC'D BY REGISTRAR <u>4-18-56</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>                     |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use executive the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

STATE DEPARTMENT OF HEALTH - BANGKOK 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| NAME OF DECEASED<br>SEX<br>AGE<br>DATE OF BIRTH   |  | PLACE OF BIRTH<br>OCCUPATION<br>RELIGION |  |
| DATE OF DEATH<br>TIME OF DEATH<br>PLACE OF DEATH  |  | CAUSE OF DEATH<br>MANNER OF DEATH        |  |
| SIGNATURE OF MEDICAL EXAMINER<br>NAME OF HOSPITAL |  | SIGNATURE OF WITNESS<br>NAME OF WITNESS  |  |

BUREAU V. S.

APR 20, 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4214

## CERTIFICATE OF DEATH

04190  
2/6

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION <u>Suburban Hospital</u>  |  |  |  | d. STREET ADDRESS <u>8600 Old Georgetown Rd.</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Core</u> Middle <u>Lavinia</u> Last <u>Fisher</u>   |  |  |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>20</u> Year <u>1956</u>   |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>March 24, 1884</u>                                      |  |
| 9. AGE (In years last birthday) <u>72</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>26</u> Hours <u></u> Min. <u></u> |  | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Nurse's Aide</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hospital</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Frederick Co., Md.</u>         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><u>Thomas M. Gaha</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Martha Lavinia Smith</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) <u>Unknown</u>  |  | 17. INFORMANT<br>Address <u>Raymond C. Fisher-200 Horners Lane, Rockv. Md.</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage on left</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral artery sclerosis</u><br>DUE TO (c) <u>Hypertension</u> |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>7 yrs</u><br><u>15 yrs</u>  |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. n. p. m. 19   |  |  |  |   |  |  |  |
| 20d. INJURY OCCURRED While Not while<br>of work at work   |  |  |  |   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |   |  |  |  |
| 20f. (City or town) (County) (State)  |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <u>18 April, 1956</u> to <u>20 April, 1956</u> , that I last saw the deceased alive on <u>19 April, 1956</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ADDRESS (Street, city or town, state) DATE SIGNED   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Merton L. White</u> M.D. <u>11/24 George Ave. Beth. Md. 20 yrs.</u>   |  |  |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Merton L. White M.D.</u>   |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>4/22/1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Potomac Methodist</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Potomac Maryland</u>       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>   |  |  |  | ADDRESS<br><u>7557 Wis. Ave. Beth. Md.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>4/21/56</u>                                 |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Bessie M. Thompson</u>   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4215

## CERTIFICATE OF DEATH

04191

Reg. Dist. No. 216

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Suburban Hosp.</u>   |                                  | d. STREET ADDRESS<br><u>Route 3, Congraft Road</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Rose</u> Middle <u>Yates</u> Last <u>Forrester</u>  |                                  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>26</u> Year <u>1956</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 5, 1884</u> |
| 9. AGE (In years last birthday)<br><u>71</u> yrs.   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>10</u> Days <u>21</u> Hours <u></u> Min. <u></u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Conciliator</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dept. of Labor</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Worcester, Mass.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Joseph E. Yates</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Casey</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   |
| 17. INFORMANT<br><u>Niece, Mrs. David DeWiler</u>   |                                  | Address <u>3436 Crampian, Williamsport, Pa</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Thrombosis right coronary</u><br>DUE TO <u>Atherosclerosis Coronaries</u><br>(c) <u></u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>1 day</u><br><u>? years</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Early Bronchopneumonia</u>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>Feb</u> , 195 <u>2</u> , to <u>26 April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>26 April</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE<br><u>W. S. Murphy</u>   |                                  | ADDRESS (Street, city or town, state)<br><u>665 W. Mount Pleasant Rd Rockville Md 284</u>  |   |
| PHYSICIAN'S NAME (Type)<br><u>W. S. Murphy</u>  |                                  | DATE SIGNED<br><u>28 April 56</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Apr. 30, 1956</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Rockville Maryland</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</u>   |                                  | 24a. REC'D BY REGISTRAR<br><u>29-56</u>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Bessie M. Thompson</u>   |                                  |  |   |

RECEIVED

MARYLAND

4216

## CERTIFICATE OF DEATH

04192  
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 214

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY <u>Montg.</u>                       |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>3 yrs</u>        |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>36</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8511 Old Bladensburg Rd</u>  |                               | STREET ADDRESS (If rural, give location) <u>8511 Old Bladensburg Rd</u>                                   |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Adele</u> (First) (Middle) (Last) <u>Gadol</u>                            |                               | 4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 1 1956</u>   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>   | 8. DATE OF BIRTH <u>Nov 25 1889</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                         |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE last birthday <u>66</u> yrs. If under 1 year 1 month 1 day 1 hour 1 min. |
| 11. BIRTHPLACE (State or foreign country) <u>Romania</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |   |
| 13. FATHER'S NAME   |                               | 14. MOTHER'S MAIDEN NAME  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) |                               | 16. SOCIAL SECURITY No. <u>None</u>   |   |
| 17. INFORMANT AND ADDRESS <u>Ellis Gadol Silver Spring, Md.</u>   |                               |   |   |

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X Immediate cause (a) Metastatic Carcinoma

Antecedent cause(s) (b) ? Carcinoma of Cervix ?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

8 mo.

?

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1955, to Apr 1, 1956, that I last saw the deceasedalive on Apr 1, 1956, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

1 A. F. Thibodeau and John L. Avery MD 10110 Georgia Ave, Silver Spring Md 4/1/56

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-3-56Frances PotterGretheg Funeral Home - 4217-9 St. X

MARGIN RESERVED FOR BINDING

RECEIVED

BUREAU V. S.

APR 5 1906

RECEIVED

## 4217 CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |  |  |                          |
|---|--|--|--------------------------|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                          |
| COUNTY <i>Montgomery</i>  | MARYLAND   | STATE <i>Md.</i>   | COUNTY <i>Montgomery</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <i>Bethesda</i>   | LENGTH OF STAY (in this place)<br><i>10 days</i> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <i>Chevy Chase</i>   |                          |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><i>Resmor Hospital</i><br><i>5721 Grosvenor Lane</i>   |  | STREET ADDRESS (If rural give location)<br><i>3907 Virginia St.</i>  |                          |
| 3. NAME OF DECEASED:  |  | 4. DATE OF DEATH:  |                          |
| (First) <i>Edith</i>  | (Middle) <i>Mary Weston</i>                      | (Last) <i>Gagge</i>  |                          |
| 5. SEX: <i>Female</i>   |  | 6. DATE OF BIRTH: <i>Oct. 20, 1878</i>   |                          |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>  |  | 8. AGE last birthday: <i>77</i> yrs. <i>5</i> Months <i>29</i> Days  |                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>   |                          |
| 11. BIRTHPLACE (State or foreign country): <i>Ipswich, England</i>  |  | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |                          |
| 13. FATHER'S NAME: <i>Arthur Smith</i>  |  | 14. MOTHER'S MAIDEN NAME: <i>MARIA Jakes</i>   |                          |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>No</i>   |  | 16. SOCIAL SECURITY NO.: <i>Unknown</i>  |                          |
| 17. INFORMANT & ADDRESS: <i>Col. A.P. Gagge - Chevy Chase, Md.</i>  |  |  |                          |
| 18. MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH   |                          |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |                          |
| IMMEDIATE CAUSE (A) <i>metastatic Carcinoma of Breast, widespread</i>   |  | <i>10 years</i>  |                          |
| ANTECEDENT CAUSE (B) <i>Carcinoma of Breast</i>   |  | <i>10+ years</i>   |                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.  |  |  |                          |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |                          |
| 19A. DATE OF OPERATION:   |  | 19B. MAJOR FINDINGS OF OPERATION   |                          |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |                          |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |                          |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |  |  |                          |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                          |
| 21F. HOW DID INJURY OCCUR?  |  |  |                          |
| 22. I hereby certify that I attended the deceased from <i>4/9</i> , 19 <i>56</i> , to <i>4/19</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4/15</i> , 19 <i>56</i> , and that death occurred at <i>9:16</i> A.M. from the causes and on the date stated above. |  |  |                          |
| SIGNATURE <i>Charles J. Savarese, Jr.</i>   |  | DATE SIGNED <i>4/19/56</i>   |                          |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial-transit</i>  |  | DATE THEREOF <i>4/20/1956</i>  |                          |
| NAME OF CEMETERY OR CREMATORY <i>Hollywood</i>  |  | LOCATION (City, town, or county) (State) <i>Henrico Co. Virginia</i>   |                          |
| DATE REC'D BY LOCAL REGISTRAR <i>4/21/56</i>  |  | REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>  |                          |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>  |  | ADDRESS <i>Bethesda, Maryland</i>  |                          |

MARGIN RESERVED FOR BINDING



COLLIER COUNTY, FLA.

VEGETABLE BOND

EXCISE



BUREAU V. S.

APR 23 1956

RECEIVED

Reg. Dist. No.

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>   |                               | c. LENGTH OF STAY IN 1b <u>10 Months</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>GENEVA B. GALLOWAY</u>   |                               | 4. DATE OF DEATH <u>APRIL 28 1956</u>  |  |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 19, 1916</u> |
| 9. AGE (In years last birthday) <u>40</u> yrs.  |                               | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>GEORGE MALBY</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>CLAMZY CARVER</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>578-38-6716</u>   |  |
| 17. INFORMANT <u>JAMES E. Galloway</u>  |                               | Address <u>1052 RUATAN ST. SS MD</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE Pulmonary Edema</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u><br>DUE TO (c) <u>Coronary Atherosclerosis</u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Hours</u><br><u>3 Days</u><br><u>Unknown</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Hour <u>12:15 PM</u> Month <u>APRIL</u> Day <u>28</u> Year <u>1956</u>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>APRIL 25, 1956</u> , to <u>APRIL 28, 1956</u> , that I last saw the deceased alive on <u>APRIL 28, 1956</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.   |                               |  |  |
| ACTUAL SIGNATURE <u>JACK CROWELL</u>  |                               | M.D. <u>2025 EYE ST., N.W. WASH., D.C.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>   |                               | DATE SIGNED  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 22b. DATE THEREOF <u>5/1/56</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE UNION CEMETERY</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner B. Humphrey</u>  |                               | ADDRESS <u>SILVER SPRING, MD.</u>  |  |
| 24a. REC'D BY REGISTRAR <u>DATE 4/30/56</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>   |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219

## CERTIFICATE OF DEATH

Reg. Dist. No. 04195

|   |                                |   |   |
|---|--------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>VIRGINIA</b> b. COUNTY <b>FAIRFAX</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>   |                                | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FALLS CHURCH</b> |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>U.S. NAVAL HOSPITAL</b>   |                                | d. STREET ADDRESS<br><b>1709 LEE PARK COURT</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>LOIS DOROTHY GARBUSCHEWSKI</b>   |                                | 4. DATE OF DEATH<br>Month Day Year<br><b>APRIL 20 1956</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>CAU</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-27-27</b>  |
| 9. AGE (In years last birthday)<br><b>29</b>  |                                | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>CALIFORNIA</b>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>CHESTER HILL DEC.</b>   |                                | 14. MOTHER'S MAIDEN NAME<br><b>DOROTHY SINGLETON DEC.</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                                | 16. SOCIAL SECURITY NO.<br><b>549 302 774</b>   |   |
| 17. INFORMANT<br>Address: <b>FALLS CHURCH VA.</b>   |                                | 17. INFORMANT<br><b>HORST GARBUSCHEWSKI 1709 LEE PARK COURT</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cereurysm, Basilar Artery &amp; hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs</b> |                                |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>19 APRIL 1956</b> , to <b>20 APRIL 1956</b> , that I last saw the deceased alive on <b>20 APRIL 1956</b> , and that death occurred at <b>9:25 PM</b> , from the causes and on the date stated above.   |                                |   |   |
| ACTUAL SIGNATURE <b>R.W. Mackie</b>   |                                | ADDRESS (Street, city or town, state) <b>USNH, NMMC, Bethesda, Maryland</b>   |   |
| DATE SIGNED <b>4-20-56</b>  |                                |   |   |
| PHYSICIAN'S NAME (Type) <b>R.W. MACKIE CDR MC USN</b>   |                                | U.S. NAVAL HOSPITAL NMMC BETHESDA MD.   |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                | 22b. DATE THEREOF<br><b>26 Apr 56</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>RIVERVIEW CEMETERY</b>   |                                | 22d. LOCATION (City, town, or county) (State)<br><b>ST. JOSEPH MICHIGAN</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.A. PUMPHREY</b>  |                                | 24a. REC'D BY REGISTRAR<br><b>21 Apr 56</b>   |   |
| ADDRESS <b>BETHESDA, MD</b>   |                                | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Donnelly</b>   |   |
| 25. ADDRESS <b>7557 WISCONSIN AVE</b>   |                                |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4220

## CERTIFICATE OF DEATH

04196

Reg. Dist. No. 217

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Colesville</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Colesville</b>   |  |
| c. LENGTH OF STAY IN 1b<br><b>15</b>  |                                  | d. STREET ADDRESS<br><b>Box 103 Silver Spring</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Myrtle</b> Middle <b>Irene</b> Last <b>Gates</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>6</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 12 1901</b> |
| 9. AGE (In years last birthday) yrs.<br><b>54</b>   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Algernon Johnson</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Grimsley</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>#####</b> (If yes, give year or date of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>216 18 0782</b>   |  |
| 17. INFORMANT<br><b>George A. Gates</b>   |                                  | Address<br><b>Box 103 Silver Spring</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Glioblastoma Multiforme of brain</b><br>193X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12-15 m.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July 20, 1955</b> , to <b>April 6, 1956</b> , that I last saw the deceased alive on <b>April 6, 1956</b> , and that death occurred at <b>12:00 P. M.</b> from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE<br><b>William D. Aud</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>9006 Colsvll. Rd, Silver Spring</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. William D. Aud</b>  |                                  | DATE SIGNED   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>April 9 56</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Jennings Chapel</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Howard Co. Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Roy W. Barber</b>  |                                  | ADDRESS<br><b>Laytonsville, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>4-10-56</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Lester B. Lowry</b>  |  |

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Journal of Cellular Biochemistry

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BUREAU V. S.

APR 13 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04197

4221

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

|   |                           |  |  |  |  |  |  |
|---|---------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. COUNTY <u>Montgomery</u> STATE <u>Maryland</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>   |                           |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp.</u>  |                           |  |  | d. STREET ADDRESS <u>8215 Garland Ave.</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Gillespie</u> Last <u>Gillespie</u>  |                           |  |  | 4. DATE OF DEATH Month <u>Apr-</u> Day <u>10</u> Year <u>1956</u>  |  |  |  |
| 5. SEX <u>M-</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 15 - 1865</u> | 9. AGE (In years last birthday) <u>90</u> yrs.   | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min.                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lumber salesman</u>  |                           |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ferna-</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>U.S.-H.</u>       |  |
| 13. FATHER'S NAME <u>?</u>  |                           |  |  | 14. MOTHER'S MAIDEN NAME <u>Cunningham</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |                           |  |  | 16. SOCIAL SECURITY NO. <u>156-10-8681A</u>  |  | 17. INFORMANT <u>Daughter 8215 Garland Ave. Takoma Park Md</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute Sub Arterioventricular Hemorrhage</u><br>443X DUE TO <u>Sen. Arteriosclerotic Cardia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arteriosclerosis + Hypertension</u><br>(b) <u>Arteriosclerosis + Hypertension</u><br>(c) <u>Arteriosclerosis + Hypertension</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a) <u>8 Days</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>8 y</u> |                           |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                           |  |
| 21. I certify that I attended the deceased from <u>Apr 3</u> , 19 <u>56</u> , to <u>Apr 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 10</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above.  |                           |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>John Basley Ziegler</u> M.D.  |                           |  |  | ADDRESS (Street, city or town, state) <u>Olney, Md</u>   |  | DATE SIGNED <u>4-10-56</u>                                     |  |
| PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>  |                           |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                  |  |
| <u>Transit Burial</u>   |                           | <u>April 12, 1956</u>  |  | <u>Oak Hill Cemetery</u>   |  | <u>Vineland, New Jersey</u>                                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St. NW Apt</u>   |                           |  |  | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE <u>Gertrude Bowler</u>              |  |
|   |                           |  |  | DATE <u>4-12-56</u>  |  |  |  |

BUREAU V. S.

APR 16 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04198

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

4222

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |                                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>  |                                  |   | d. STREET ADDRESS <b>8201 Kentbury Drive</b>  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Newell Canfield Granger</b>  |                                  |   | 4. DATE OF DEATH Month Day Year<br><b>April 14, 1956</b>  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-13-04</b>  |  | 9. AGE (In years lost birthday) <b>52</b> yrs. IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Architect</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Govt.</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |                                  |   |   |  |   |
| 13. FATHER'S NAME<br><b>Arthur L. Granger</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Annie West</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   | 17. INFORMANT <b>Wife</b> Address <b>Gertrude P. Granger 8201 Kentbury Dr., Beth., Md.</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion -</b><br>DUE TO (b) <b>coronary arterio sclerosis</b><br>DUE TO (c) <b>arterio sclerosis generalised</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. g. 19<br>p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>April 14, 1956</b> to <b>April 14, 1956</b> that I last saw the deceased alive on <b>April 14, 1956</b> , and that death occurred at <b>3:20</b> M, from the causes and on the date stated above.   |                                  |   |   |  |   |
| ACTUAL SIGNATURE <b>Alfred S. Norton</b>   |                                  | M.D. <b>4711 Highland Ave.,</b>   |   | DATE SIGNED <b>4/14/56</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Alfred S. Norton</b>  |                                  | <b>Bethesda, Maryland</b>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>  |                                  | 22b. DATE THEREOF <b>4-17-56</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY <b>Kensico Cemetery</b>                                 |   |
| 22d. LOCATION (City, town, or county) (State) <b>West Chester Co., N. Y.</b>   |                                  | 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>  |   | ADDRESS <b>Bethesda, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR <b>4-17-56</b>   |                                  | 24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>  |   |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

APR 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04199

4223

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>5 days</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>College Park</b>   |                                  | d. STREET ADDRESS<br><b>6903 Baltimore Ave.,</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NMMC, Bethesda, Md.</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Noah</b> Middle <b>(n)</b> Last <b>GULLETT</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>24</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>    | 8. DATE OF BIRTH<br><b>Feb. 2, 1874</b>            |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>14</b> Hours <b>24</b> Min. <b>14</b>   | IF UNDER 24 HRS.<br>Hours <b>14</b> Min. <b>14</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Lawyer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lawyer</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |
| 13. FATHER'S NAME<br><b>William GULLETT (Deceased)</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Julia Hungerford (Deceased)</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>unknown</b>   |  |
| 17. INFORMANT<br><b>(Son) William W. GULLETT (Same as #2)</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO <b>G</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>G</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Generalized atherosclerosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>19 April</b> , 19 <b>56</b> , to <b>24 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>24 April</b> , 19 <b>56</b> , and that death occurred at <b>9:50A.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                                  |  |  |
| ACTUAL SIGNATURE <b>Dominic A. Brancazio</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>   |                                  |  |  |
| PHYSICIAN'S NAME (Type) <b>Dominic A. Brancazio, LT, MC, USNR U.S. Naval Hospital, Bethesda, Md.</b>  |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4-28-56</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Odd Fellows Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Elizabethtown, Illinois</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.A. PUMPHREY</b>  |                                  | ADDRESS <b>Bethesda, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>4-24-56</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Passelly</b>  |  |

CERTIFICATE OF DEATH

|  |  |                                  |  |                                      |  |
|--|--|----------------------------------|--|--------------------------------------|--|
| 1. NAME OF DECEASED<br>JAMES H. HARRIS     |  | 2. SEX<br>Male                   |  | 3. AGE<br>65                         |  |
| 4. DATE OF DEATH<br>April 26, 1956         |  | 5. TIME OF DEATH<br>10:00 AM     |  | 6. PLACE OF DEATH<br>Home            |  |
| 7. CAUSE OF DEATH<br>Myocardial Infarction |  | 8. MANNER OF DEATH<br>Natural    |  | 9. PLACE OF BIRTH<br>Baltimore, Md.  |  |
| 10. OCCUPATION<br>None                     |  | 11. EDUCATION<br>High School     |  | 12. RELIGION<br>None                 |  |
| 13. MARITAL STATUS<br>Married              |  | 14. DATE OF MARRIAGE<br>1925     |  | 15. NAME OF SPOUSE<br>Mary H. Harris |  |
| 16. NAME OF PHYSICIAN<br>Dr. J. H. Harris  |  | 17. NAME OF HOSPITAL<br>None     |  | 18. NAME OF NURSE<br>None            |  |
| 19. NAME OF FUNERAL HOME<br>None           |  | 20. NAME OF BURIAL PLACE<br>None |  | 21. NAME OF CEMETERY<br>None         |  |
| 22. NAME OF INTERVIEWER<br>None            |  | 23. NAME OF WITNESS<br>None      |  | 24. NAME OF SIGNER<br>None           |  |
| 25. NAME OF SIGNER<br>None                 |  | 26. NAME OF SIGNER<br>None       |  | 27. NAME OF SIGNER<br>None           |  |
| 28. NAME OF SIGNER<br>None                 |  | 29. NAME OF SIGNER<br>None       |  | 30. NAME OF SIGNER<br>None           |  |
| 31. NAME OF SIGNER<br>None                 |  | 32. NAME OF SIGNER<br>None       |  | 33. NAME OF SIGNER<br>None           |  |
| 34. NAME OF SIGNER<br>None                 |  | 35. NAME OF SIGNER<br>None       |  | 36. NAME OF SIGNER<br>None           |  |
| 37. NAME OF SIGNER<br>None                 |  | 38. NAME OF SIGNER<br>None       |  | 39. NAME OF SIGNER<br>None           |  |
| 40. NAME OF SIGNER<br>None                 |  | 41. NAME OF SIGNER<br>None       |  | 42. NAME OF SIGNER<br>None           |  |
| 43. NAME OF SIGNER<br>None                 |  | 44. NAME OF SIGNER<br>None       |  | 45. NAME OF SIGNER<br>None           |  |
| 46. NAME OF SIGNER<br>None                 |  | 47. NAME OF SIGNER<br>None       |  | 48. NAME OF SIGNER<br>None           |  |
| 49. NAME OF SIGNER<br>None                 |  | 50. NAME OF SIGNER<br>None       |  | 51. NAME OF SIGNER<br>None           |  |
| 52. NAME OF SIGNER<br>None                 |  | 53. NAME OF SIGNER<br>None       |  | 54. NAME OF SIGNER<br>None           |  |
| 55. NAME OF SIGNER<br>None                 |  | 56. NAME OF SIGNER<br>None       |  | 57. NAME OF SIGNER<br>None           |  |
| 58. NAME OF SIGNER<br>None                 |  | 59. NAME OF SIGNER<br>None       |  | 60. NAME OF SIGNER<br>None           |  |
| 61. NAME OF SIGNER<br>None                 |  | 62. NAME OF SIGNER<br>None       |  | 63. NAME OF SIGNER<br>None           |  |
| 64. NAME OF SIGNER<br>None                 |  | 65. NAME OF SIGNER<br>None       |  | 66. NAME OF SIGNER<br>None           |  |
| 67. NAME OF SIGNER<br>None                 |  | 68. NAME OF SIGNER<br>None       |  | 69. NAME OF SIGNER<br>None           |  |
| 70. NAME OF SIGNER<br>None                 |  | 71. NAME OF SIGNER<br>None       |  | 72. NAME OF SIGNER<br>None           |  |
| 73. NAME OF SIGNER<br>None                 |  | 74. NAME OF SIGNER<br>None       |  | 75. NAME OF SIGNER<br>None           |  |
| 76. NAME OF SIGNER<br>None                 |  | 77. NAME OF SIGNER<br>None       |  | 78. NAME OF SIGNER<br>None           |  |
| 79. NAME OF SIGNER<br>None                 |  | 80. NAME OF SIGNER<br>None       |  | 81. NAME OF SIGNER<br>None           |  |
| 82. NAME OF SIGNER<br>None                 |  | 83. NAME OF SIGNER<br>None       |  | 84. NAME OF SIGNER<br>None           |  |
| 85. NAME OF SIGNER<br>None                 |  | 86. NAME OF SIGNER<br>None       |  | 87. NAME OF SIGNER<br>None           |  |
| 88. NAME OF SIGNER<br>None                 |  | 89. NAME OF SIGNER<br>None       |  | 90. NAME OF SIGNER<br>None           |  |
| 91. NAME OF SIGNER<br>None                 |  | 92. NAME OF SIGNER<br>None       |  | 93. NAME OF SIGNER<br>None           |  |
| 94. NAME OF SIGNER<br>None                 |  | 95. NAME OF SIGNER<br>None       |  | 96. NAME OF SIGNER<br>None           |  |
| 97. NAME OF SIGNER<br>None                 |  | 98. NAME OF SIGNER<br>None       |  | 99. NAME OF SIGNER<br>None           |  |
| 100. NAME OF SIGNER<br>None                |  | 101. NAME OF SIGNER<br>None      |  | 102. NAME OF SIGNER<br>None          |  |

BUREAU V. B.

APR 26 1956

MD-100

4224

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville (Rural)</i>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>74 Serbanon Hosp</i>   |                               | d. STREET ADDRESS <i>RFD</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><i>CLARENCE W. HALLER</i>   |                               | 4. DATE OF DEATH Month Day Year<br><i>April 30 1956</i>  |  |
| 5. SEX <i>M</i>  | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>29 April 56</i>                |
| 9. AGE (In years last birthday) yrs. <i>19</i>   |                               | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>  |                               | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  |
| 13. FATHER'S NAME <i>Clarence Haller</i>   |                               | 14. MOTHER'S MAIDEN NAME <i>Wonda Fink</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <i>None</i>  |  |
| 17. INFORMANT <i>Father-Item # 2</i>   |                               | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Failure</i><br><i>773.5</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>immaturity</i><br>(c) <i>prematurity</i> |                               |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>19 hrs.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>29 April, 1956</i> , to <i>30 April, 1956</i> , that I last saw the deceased alive on <i>29 April, 1956</i> , and that death occurred at <i>12 + A</i> M, from the causes and on the date stated above.   |                               |  |  |
| ACTUAL SIGNATURE <i>Vincent L. O'Donnell</i> M.D.  |                               | ADDRESS (Street, city or town, state) <i>8218- Wise Ave Beth 30 April</i> DATE SIGNED  |  |
| PHYSICIAN'S NAME (Type) <i>Vincent L. O'Donnell</i>  |                               |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                               | 22b. DATE THEREOF <i>4-5-3-56</i>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Parson</i>   |                               | 22d. LOCATION (City, town, or county) (State) <i>Parson, W. Va.</i>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Robert A. Pumphrey-Bethesda, Md.</i>   |                               | 24a. REC'D BY REGISTRAR DATE <i>4/30/56</i>  |  |
|  |                               | 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074282291





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director, may be retained by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4225  
CERTIFICATE OF DEATH

04201

Reg. Dist. No.

216

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Dist. of Col.</u> b. COUNTY                         |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>   |  |   |  |
| c. LENGTH OF STAY IN 1b <u>1 hr. 45 min</u>   |  |  |  | 47X-3 ✓  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>  |  |  |  | d. STREET ADDRESS <u>3273 Prospect Ave.</u>  |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Hammond</u> Last <u>Hammond</u>   |  |  |  | 4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>   |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>March 29, 1913</u>                          |  |
| 9. AGE (In years last birthday) <u>43</u> yrs.  |  | IF UNDER 1 YEAR Months <u>43</u> Days <u>43</u> Hours <u>43</u> Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  |
| 13. FATHER'S NAME <u>Frank Hamerman</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Eva Apter</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>114-10-3995</u>   |  |   |  |
| 17. INFORMANT <u>Paul Burman</u>  |  |  |  | Address <u>2921 Greenvale Rd. Chevy Chase, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u><br>DUE TO <u>Myocardial infarction</u><br>(c) <u>Myocardial infarction</u> |  |  |  |  |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u><br><u>2 hrs</u>  |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m.  |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <u>4/16/56</u> , 19 <u>56</u> , to <u>4/16/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/16/56</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.                                  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Stephen D. Jones</u> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <u>Romulo 2nd</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Stephen D. Jones</u>   |  |  |  | DATE SIGNED <u>4/16/56</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>4-18-1956</u>                                   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>OAKHILL CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>WASH, D.C.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>3072-M St. N.W.</u>  |  |  |  | 24a. REC'D BY REGISTRAR <u>ADD 10</u>  |  |   |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>  |  |   |  |

CERTIFICATE OF DEATH

4535

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mirrored and difficult to read.

BUREAU V. S.

APR 18 1956

RECEIVED

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mirrored and difficult to read.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4158

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04202

Reg. Dist. No. 223

|   |   |   |   |   |  |   |   |
|---|---|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>Ind</u> b. COUNTY <u>Monty</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |   | c. LENGTH OF STAY IN 1b<br><u>5 years</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>                              |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>216 Grant Ave</u>  |   |   |   | d. STREET ADDRESS<br><u>216 Grant Ave</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Patrick</u> Middle <u>Francis</u> Last <u>Hart</u>  |   |   |   | 4. DATE OF DEATH<br>Month <u>Apr</u> Day <u>16</u> Year <u>1956</u>   |  |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 9 1862</u>                             | 9. AGE (In years last birthday)<br><u>93</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>                           |   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>refrigerator</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Furniture</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Ireland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Not Available</u>   |   |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Not Available</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |   | 16. SOCIAL SECURITY NO.<br><u>471-10-9571A</u>  |   | 17. INFORMANT<br>Address <u>Joe M. Hart (Son) Same as Item 2</u>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>DUE TO<br>(c) <u>  </u>  |   |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   |   | (County)   | (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |   |   |  |   |   |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.   |   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>  |   |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |
|   |   |   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>TRANSIT BURIAL</u>  |   | 22b. DATE THEREOF<br><u>APR. 21. 1956</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>St Michaels Cemetery</u> |   | 22d. LOCATION (City, town, or county) (State)<br><u>Stillwater Minnesota</u> |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. Arthur Walters, 254 Carroll St NW DC</u>  |   |   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>4/16/56</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>John N. ...</u>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4158

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. B.

APR 19 1956

RECEIVED

4226

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

|   |                            |  |                                   |
|---|----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH: <u>Asbury mzh. Home</u><br>COUNTY <u>Montgomery</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Griffithsburg</u> LENGTH OF STAY (in this place) <u>7 years</u><br>TOWN <u>Griffithsburg</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Asbury mzh. Home</u><br><u>Griffithsburg Md.</u> |                            | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Md.</u> COUNTY <u>Montgomery</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Griffithsburg</u> OR TOWN <u>Griffithsburg</u><br>STREET ADDRESS (If rural give location) <u>Rolling Acres</u> |                                   |
| 3. NAME OF DECEASED: (First) <u>Grace</u> (Middle) <u>Eugenia</u> (Last) <u>Hause</u>   |                            | 4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>17</u> <u>1956</u>  |                                   |
| 5. SEX: <u>Fe.</u>  | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>widowed</u>  | 8. DATE OF BIRTH: <u>2-5-1875</u> |
| 9. AGE last birthday <u>81</u> yrs.   |                            | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>   |                            | 10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>  |                                   |
| 11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>   |                            | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                   |
| 13. FATHER'S NAME: <u>Andrew T. HARVEY</u>  |                            | 14. MOTHER'S MAIDEN NAME: <u>Virginia Warner</u>   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (No, or unk.)) (If Yes, give war or dates of service)   |                            | 16. SOCIAL SECURITY NO. <u>—</u>   |                                   |
| 17. INFORMANT & ADDRESS: <u>Miss C. N. Eareckson-Robers Ave.</u>  |                            |  |                                   |
| 18. MEDICAL CERTIFICATION   |                            |  |                                   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                            |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (A) <u>Cerebral Vascular accident</u>   |                            |  | <u>36 hrs</u>                     |
| ANTECEDENT CAUSE (S): (B) <u>arteriosclerosis, Hypertension</u>   |                            |  | <u>20 yrs</u>                     |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive heart disease</u>   |                            |  | <u>20 yrs</u>                     |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                            |  |                                   |
| 19A. DATE OF OPERATION:   |                            | 19B. MAJOR FINDINGS OF OPERATION   |                                   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |                                   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |                                   |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?  |                            |  |                                   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                            | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |                                   |
| 21F. HOW DID INJURY OCCUR?  |                            |  |                                   |
| 22. I hereby certify that I attended the deceased from <u>12-28</u> , 19 <u>55</u> , to <u>4-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-16</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.   |                            |  |                                   |
| SIGNATURE <u>Sarah Elizabeth Blower</u>   |                            | ADDRESS <u>M. D. 4208 Anthony St Kensington, Md.</u> DATE SIGNED <u>4-17-56</u>  |                                   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |                            | DATE THEREOF <u>4/20/56</u>  |                                   |
| NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>  |                            | LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>  |                                   |
| DATE REC'D BY LOCAL REGISTRAR <u>April 19, 1956</u>   |                            | REGISTRAR'S SIGNATURE <u>A. W. Hedrich</u>   |                                   |
| 24. FUNERAL DIRECTOR <u>Wm. J. Dickerson &amp; Sons</u>   |                            | ADDRESS <u>Baltimore</u>   |                                   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04204

4227

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

|   |                                    |   |   |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Purdum</b>   |                                    | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>R.F.D. # 1 Clarksburg</b>  |                                    | d. STREET ADDRESS<br><b>R.F.D. # 1 Clarksburg</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Darrell</b> Middle <b>R.</b> Last <b>Hawkins</b>  |                                    | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>1956</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>March 28, 1956</b> |
| 9. AGE (In years lost birthday) yrs. <b>1</b> Months <b>2</b> Days <b>1</b> Hours <b>2</b> Min.   |                                    | IF UNDER 1 YEAR <b>1</b> IF UNDER 24 HRS. <b>2</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Olney, Md.</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Hamilton Hawkins</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Madeline Hebron</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                                    | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Mrs Hamilton Hawkins, Clarksburg, Md.</b>   |                                    | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Gastro-enteritis (Infectious)?</b><br><b>571.0</b><br>DUE TO * (NOTE: Child seen once only by us and died before it was taken to hospital as arranged.<br>(b) <b>Was in terminal stage of dehydration from prolonged lying cause lost.</b><br>(c) <b>vomiting and diarrhea, untreated.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                    |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days.</b>  |                                    |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>seen as emergency once only</b> , 19 <b>1956</b> , that I last saw the deceased alive on <b>April 30</b> , 19 <b>1956</b> , and that death occurred at <b>5 a.m.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Damascus, Maryland</b><br>DATE SIGNED <b>4/30/56</b><br>ACTUAL SIGNATURE <b>M. McKendree Boyer</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M. D. Druid Theatre Building.</b>   |                                    |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 22b. DATE THEREOF<br><b>April 30, 1956</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Plesant Grove</b>  |                                    | 22d. LOCATION (City, town, or county) (State)<br><b>Purdum, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Olin L. Mobsworth</b>  |                                    | 24a. REC'D BY REGISTRAR<br><b>April 30, 1956</b>  |   |
| ADDRESS<br><b>Damascus, Md.</b>   |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Della W. Burdette</b>  |   |

2073276445

RECEIVED

MAY 2 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04205

214

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton Hills Sil. Spg.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton Hills Silver Spring, Md. 56</b>                              |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |   | d. STREET ADDRESS<br><b>3115 Parker St.</b>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Luie</b> Middle <b>Lindon</b> Last <b>Hayes</b>  |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>25</b> Year <b>1956</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 4, 1877</b>   |
| 9. AGE (In years last birthday) yrs. <b>79</b>   |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Elec. Contractor</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Culpepper Va.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b> (If yes, give year or date of service)<br><b>1893-1898</b>   |   | 16. SOCIAL SECURITY NO.<br><b>?</b>   |  |
| 17. INFORMANT<br><b>Helen G Hayes</b>  |   | Address<br><b>3115 Parker St.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hours</b><br><b>10 years</b>                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. n. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>May</b> , 19 <b>46</b> , to <b>4/25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/24</b> , 19 <b>55</b> , and that death occurred at <b>2:20</b> P. M. from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE<br><b>James T. Burns</b>  |   | ADDRESS (Street, city or town, state)<br><b>915-19th St NW</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>JAMES T. BURNS M.D.</b>  |   | DATE SIGNED<br><b>4/25/56</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>4/28/56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Bladensburg, Md.</b>                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Deal Funeral Home</b>   |   | ADDRESS<br><b>4812 Ga. Ave. N. W.</b>   | 24a. REC'D BY REGISTRAR<br><b>4/25/56</b>  |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Francis P. Miller</b>  |  |

NOTHING BUT THE BEST



4229

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                     |   |  |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>1 day</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>St. Mary's</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>California</b><br>d. STREET ADDRESS<br><b>Bay View Traylor Park</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Willie</b><br>Middle<br><b>Mae</b><br>Last<br><b>HAYES</b>   |                                     | 4. DATE OF DEATH<br>Month<br><b>April</b><br>Day<br><b>15</b><br>Year<br><b>1956</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>November 17, 1927</b>                             |
| 9. AGE (In years last birthday)<br><b>28</b> yrs.   |                                     | IF UNDER 1 YEAR<br>Months<br><b>28</b>  | IF UNDER 24 HRS.<br>Hours<br><b>28</b><br>Min.<br><b>28</b>              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>              |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |                                     | 13. FATHER'S NAME<br><b>"D" Frost</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Nena A. Perry</b>  |                                     | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |                                     | 17. INFORMANT<br><b>(Husband) Delbert HAYES, Bay View Traylor Park</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b><br><b>490x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hodgkin's Disease</b><br>DUE TO<br>(c) <b>1 year</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m.<br>p. m.<br><b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>14 April</b> , 19 <b>56</b> , to <b>15 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>15 April</b> , 19 <b>56</b> , and that death occurred at <b>0725A</b> M., from the causes and on the date stated above.   |                                     |   |  |
| ACTUAL SIGNATURE<br><b>Willard P. Arentzen</b>  |                                     | ADDRESS (Street, city or town, state)<br><b>U.S. Naval Hospital, Bethesda, Md.</b>  |  |
| DATE SIGNED<br><b>4-16-56</b>   |                                     |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Willard P. ARENTZEN, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.</b>  |                                     |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>4-19-56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Henagar Alabama</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Henagar, Alabama</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.A. PUMPHREY</b>  |                                     | ADDRESS<br><b>7557 Wisconsin Ave, Bethesda, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>DATE 4-15-56</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Tracy B. Russell</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04207

4230

## CERTIFICATE OF DEATH

Reg. Dist. No.

516

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Bethesda, Maryland</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>34 days</b>   |  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |                                  |   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>50 The Clinical Center, Bethesda, Md.</b>   |                                  |   | d. STREET ADDRESS<br><b>21 Wall Street</b>  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Bradford</b> Middle <b>Nelson</b> Last <b>Headley</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>12</b> , Year <b>19 56</b>  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 27, 1888</b>   | 9. AGE (In years lost birthday) yrs. <b>68</b>                         | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>15</b> Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Executive Assist. (Army)</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Army</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |   |   |  |  |
| 13. FATHER'S NAME<br><b>Caleb Headley</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Carolyn Estes</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WW I</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  |  |
| 17. INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |                                  |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>2041</b> IMMEDIATE CAUSE (a) <b>Acute Myeloblastic Leukemia</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 wks</b> |                                  |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. s. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)  |                                  | (County)  |   | (State)  |  |
| 21. I certify that I attended the deceased from <b>March 9, 1956</b> , to <b>April 12, 1956</b> , that I last saw the deceased alive on <b>April 12, 1956</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4/12/56</b> DATE SIGNED  |                                  |   |   |  |  |
| ACTUAL SIGNATURE<br><b>Claude E. Forkner, Jr.</b>  |                                  | M.D. <b>The Clinical Center</b><br><b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Claude E. Forkner, Jr., M. D.</b>  |                                  |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4/14/1956 1</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Monocacy</b>                  |  |
| 22d. LOCATION (City, town, or county)<br><b>Beallsville</b>  |                                  | (State)<br><b>Maryland</b>  |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</b><br><b>Maryland</b>   |                                  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>4/14/58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b><br><b>PR-2H</b>      |

18 BALTIMORE—HEALTH DEPARTMENT STATE AND

10-10-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04208

4231

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>  |                                  | d. STREET ADDRESS<br><b>5512 Northfield Road</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Linda</b> Middle <b>Elizabeth</b> Last <b>HINMAN</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>23</b> Year <b>1956</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-21-56</b>           |
| 9. AGE (In years last birthday) yrs.<br><b>16 1/2</b>  |                                  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>16</b>   | IF UNDER 24 HRS.<br>Hours <b>16 1/2</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Infant</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>Albert Harold HINMAN</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Caroline Blanks</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>- -</b>   |  |
| 17. INFORMANT<br><b>Father, Albert Harold HINMAN (Same As #2)</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>770.5</b> IMMEDIATE CAUSE (a) <b>Hemolytic disease of the newborn</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Rh Incompatibility</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Prematurity</b> |                                  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>60 hrs</b><br><b>60 hrs.</b>  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>21 April 1956</b> to <b>23 April 1956</b> , that I last saw the deceased alive on <b>23 April 1956</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Robert L. Baird</b>   |                                  | DATE SIGNED<br><b>4-23-56</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Robert L. Baird, LT, MC, USN</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>U.S. Naval Hospital, Bethesda, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4-25-56</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert H. Humphrey</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE 4-23-56</b>  |  |
| R.A. Pumphrey Funeral Home,<br><b>557 Wisconsin Ave., Bethesda, Md.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Parsell</b>  |  |



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

|                        |  |                        |  |                      |  |                      |  |                      |  |                      |  |                      |  |                        |  |
|------------------------|--|------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED       |  | AGE                    |  | SEX                  |  | RACE                 |  | DATE OF BIRTH        |  | PLACE OF BIRTH       |  | CITY OF BIRTH        |  | COUNTRY OF BIRTH       |  |
| JAMES H. WOODS         |  | 45                     |  | M                    |  | W                    |  | 1880                 |  | BALTIMORE            |  | MD                   |  | U.S.A.                 |  |
| DATE OF DEATH          |  | PLACE OF DEATH         |  | CITY OF DEATH        |  | COUNTRY OF DEATH     |  | DATE OF DEATH        |  | PLACE OF DEATH       |  | CITY OF DEATH        |  | COUNTRY OF DEATH       |  |
| APR 25 1956            |  | BALTIMORE              |  | MD                   |  | U.S.A.               |  | APR 25 1956          |  | BALTIMORE            |  | MD                   |  | U.S.A.                 |  |
| CAUSE OF DEATH         |  | MANNER OF DEATH        |  | OCCUPATION           |  | EDUCATION            |  | RELIGION             |  | MARRIAGE             |  | CHILDREN             |  | SOURCES OF INFORMATION |  |
| HEART DISEASE          |  | NATURAL                |  | FARMER               |  | HIGH SCHOOL          |  | METHODIST            |  | MARRIED              |  | 3                    |  | PHYSICIAN              |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS   |  |
| J. H. WOODS            |  | J. H. WOODS            |  | J. H. WOODS          |  | J. H. WOODS          |  | J. H. WOODS          |  | J. H. WOODS          |  | J. H. WOODS          |  | J. H. WOODS            |  |

BUREAU V. S.

APR 25 1956

RECEIVED

## CERTIFICATE OF DEATH

4232

Reg. Dist. No. 212

|  |                                  |  |   |   |   |   |                  |
|--|----------------------------------|--|---|---|---|---|------------------|
| 1. PLACE OF DEATH  |                                  |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED   |   |   |                  |
| COUNTY <b>Montgomery</b>   |                                  | MARYLAND   |   | STATE <b>Maryland</b> COUNTY <b>Montg.</b>  |   |   |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Boyd, R.F.D</b>  |                                  | LENGTH OF STAY (in this place)<br><b>74 yrs</b>  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Boyd, R.F.D</b> |   |   |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                  |  |   | STREET ADDRESS (If rural give location)   |   |   |                  |
| 3. NAME OF DECEASED (Type or Print)  |                                  |  |   | 4. DATE OF DEATH  |   |   |                  |
| (First) <b>Virginia</b> (Middle) <b>E</b> (Last) <b>Hodges</b>   |                                  |  |   | (Month) <b>April</b> (Day) <b>16</b> (Year) <b>1956</b>                                     |   |   |                  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED,<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>April 3 - 1882</b> | 9. AGE last birthday<br><b>74</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                  |
| 13. FATHER'S NAME<br><b>Wesley Maxwell</b>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Essie Baker</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><b>None</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT & ADDRESS<br><b>William Hodges, Bethesda, Md</b>                              |   |   |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |  |   |   |   | 18. MEDICAL CERTIFICATION   |                  |
| 151X IMMEDIATE CAUSE (A) <b>Carcinoma of the stomach</b>   |                                  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |                  |
| ANTECEDENT CAUSE(S) DUE TO (B) <b>metastasis to the liver</b>  |                                  |  |   |   |   | 2 years   |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Anemia</b>   |                                  |  |   |   |   | 1 year  |                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                  |  |   |   |   |   |                  |
| 19a. DATE OF OPERATION<br><b>None</b>  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                |   |   |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)   |                                  | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work |   | 21f. HOW DID INJURY OCCUR?  |   |   |                  |
| 22. I hereby certify that I attended the deceased from <b>7 April, 1953</b> , to <b>16 April, 1956</b> , that I last saw the deceased alive on <b>16 April, 1956</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above. |                                  |  |   |   |   |   |                  |
| SIGNATURE<br><b>John J. Lawrence, M.D.</b>   |                                  | DATE THEREOF<br><b>4/18/56</b>   |   | NAME OF CEMETERY OR CREMATORY<br><b>Mt Olivet</b>   |   | LOCATION (City, town, or county) (State)<br><b>Frederick, Md</b>                    |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                                  | 24. REC'D BY REGISTRAR<br><b>Charles W. Elgin</b>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>William B. Hilton, Barnesville</b>                   |   | ADDRESS<br><b>P.O. Boyd, Md.</b>  |                  |
| DATE<br><b>4/16/56</b>   |                                  | per <b>W.B.</b>  |   |   |   |   |                  |

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

Name of Deceased: **Montgomery**  
 Date of Birth: **July 1, 1900**  
 Sex: **Male**  
 Race: **White**  
 Date of Death: **July 1, 1900**  
 Place of Death: **Home**

Name of Informant: **William H. Hodge**  
 Address: **1000 North 1st St.**  
 City: **Baltimore**  
 State: **Md.**  
 Date of Report: **July 1, 1900**

Name of Physician: **William H. Hodge**  
 Address: **1000 North 1st St.**  
 City: **Baltimore**  
 State: **Md.**

**BUREAU V. S.**

**APR 20 1956**

**RECEIVED**

Date of Death: **4/18/00**  
 Name of Informant: **Wm. H. Hodge**

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

4159

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Pennsylvania</u> b. COUNTY <u>Pittsburgh</u>        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Antonia</u> Middle <u>None</u> Last <u>Hoffmann</u>  |  |   |  | 4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1956</u>   |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>3-29-63</u>  |  |
| 9. AGE (In years last birthday) <u>93</u> yrs.  |  | IF UNDER 1 YEAR Months <u>93</u> Days <u>29</u> Hours <u>15</u> Min. <u>5</u> |  | IF UNDER 24 HRS. Months <u>93</u> Days <u>29</u> Hours <u>15</u> Min. <u>5</u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Piano Store</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>          |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>John m Hoffmann</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Helen Simon</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  |   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |  | 17. INFORMANT Address <u>patient's Hospital chart.</u>                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.2 Angina Pectoris</u><br>DUE TO (b) <u>Cardio-Vascular Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremic State</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>11-11</u> , 19 <u>55</u> , to <u>4-29</u> , 19 <u>56</u> that I last saw the deceased alive on <u>4-29</u> , 19 <u>56</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Robert A Hare</u> M.D. ADDRESS (Street, city or town, state) <u>Takoma Park, Md</u>   |  |   |  | DATE SIGNED <u>4/29/56</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD.</u>   |  |   |  | 809 Davis Ave  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |  |
| <u>4/30/1956</u>  |  | <u>Smithfield Cemetery</u>  |  | <u>Pittsburgh, Pennsylvania</u>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  |  |   |  | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE   |  |
| <u>Joseph Gaudus Sons</u> 1756 Pa. Ave., N.W., D.C.   |  |   |  | <u>5/1/56</u>  |  | <u>J. H. Hare</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

100

2.

BUREAU V. S.

MAY 3 1956

RECEIVED



4233

CERTIFICATE OF DEATH

04211/4

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural, Silver Spring</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>10 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>90 Cedarcroft Sanitarium &amp; Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Mary Warren Horton</b>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>4 6 1956</b>   |  |  |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b>           |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10-11-29</b>  |  |
| 9. AGE (In years last birthday)<br><b>26 yrs.</b>   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington D. C.</b>         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Edgar Warren Taulbee</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Edwards.</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Charles Horton, 2305 N. 11th St., Arlington.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pyelonephritis</b><br><b>757.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Polycystic Kidneys</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>nil</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>26 years</b> |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>nil</b>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>3-27-</b> , 19 <b>56</b> , to <b>4-6-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-5-</b> , 19 <b>56</b> , and that death occurred at <b>4:05 a.m.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Arthur Huse M.D. Cedarcroft San. &amp; Hospital 4-6-56</b>  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Arthur Huse</b>   |  |  |  | PHYSICIAN'S NAME (Type) <b>Dr A. Huse</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 22b. DATE THEREOF<br><b>4-9-1956</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>                      |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Frederick D. C.</b>   |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Timothy Naylor - 5831 - 29 Ave N.W.</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>4/10/56</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Frances Potter</b>                          |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text, possibly "JOHN DOE"]  
2. SEX: [Faint text, possibly "Male"]  
3. AGE: [Faint text, possibly "45"]  
4. DATE OF BIRTH: [Faint text, possibly "1910"]  
5. PLACE OF BIRTH: [Faint text, possibly "Baltimore, Md"]  
6. OCCUPATION: [Faint text, possibly "Teacher"]  
7. CAUSE OF DEATH: [Faint text, possibly "Heart Disease"]  
8. PLACE OF DEATH: [Faint text, possibly "Home"]  
9. DATE OF DEATH: [Faint text, possibly "April 10, 1956"]  
10. SIGNATURE OF PHYSICIAN: [Faint signature]

BUREAU V. S.

APR 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original and a copy of this certificate may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04212  
2/6

4234

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda, Maryland</b>   |   | c. LENGTH OF STAY IN 1b<br><b>21 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda, Md.</b>   |   | e. STREET ADDRESS<br><b>1007 Westmoreland Road</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Gary</b> Middle <b>Lee</b> Last <b>Howard</b>  |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> , Year <b>19 56</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>June 22, 1947</b>                                    |
| 9. AGE (In years last birthday)<br><b>8</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>District of Columbia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Melvin T. Howard</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Betty Maisch</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>The Medical Record</b>  |   | Address<br><b>The Clinical Center, Bethesda, 14, Maryland</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>2043</b> <b>Acute Leukemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 mo.</b><br>DUE TO (c) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mo.</b>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>April 9, 1956</b> , to <b>April 30, 1956</b> , that I last saw the deceased alive on <b>April 30, 1956</b> , and that death occurred at <b>11:30 P.</b> M, from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE <b>Claude E. Forkner, Jr.</b> M.D.   |   | ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/1/56</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Claude E. Forkner, Jr., M. D.</b>  |   | <b>The National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>May 4, 1956</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. P. [Signature]</b> ADDRESS<br><b>Arlington, Virginia</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>5/3/56</b> 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b>  |   |



4235

## CERTIFICATE OF DEATH

04213

Reg. Dist. No. 215

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Mont</b>                              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>10 days</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |                                     | d. STREET ADDRESS<br><b>10127 Pierce Street</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Bethesda, Maryland</b>  |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ernest</b> Middle <b>Joseph</b> Last <b>HURD</b>  |                                     | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>26</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>11 June 1891</b>  |
| 9. AGE (In years last birthday)<br><b>64</b> yrs.   |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Baker</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baker</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Czechoslovakia</b>                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |                                     | 13. FATHER'S NAME<br><b>Joseph JANOWSKI</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Anna (Unknown)</b>   |                                     | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b> (If yes, give war or dates of service) <b>WW-1</b> |  |
| 16. SOCIAL SECURITY NO.<br><b>578-05-6606</b>   |                                     | 17. INFORMANT<br><b>Violet HURD, (Same As #2)</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the thyroid</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>194X</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                     |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work <input type="checkbox"/>                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |
| 20f. (City or town)   |                                     | (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>16 April</b> , 19 <b>56</b> , to <b>26 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>26 April</b> , 19 <b>56</b> , and that death occurred at <b>4:38 P.</b> M, from the causes and on the date stated above.  |                                     |  |  |
| ACTUAL SIGNATURE<br><b>Gerald I. Plitman</b>  |                                     | ADDRESS (Street, city or town, state)<br><b>U.S. Naval Hospital, Bethesda, Md.</b>   |  |
| DATE SIGNED<br><b>4-27-56</b>   |                                     | DATE SIGNED  |  |
| PHYSICIAN'S NAME (Type)<br><b>Gerald I. PLITMAN, LT, MC, USN</b>  |                                     | U.S. Naval Hospital, Bethesda, Md.   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>4-30-56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Nat'l Memorial Park</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Falls Church, Virginia</b>               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.E. Pumphrey, 8434 Georgia Ave., Silver Spg. Md.</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>4-27-56</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Casselley</b>  |                                     |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

APR 30 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04214

Reg. Dist. No. 216

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>d. STREET ADDRESS <b>4523 Middleton Lane</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>B</b> Last <b>IRVING</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>26</b> Year <b>1956</b>   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>Aug. 13-1884</b>                                   |  |
| 9. AGE (In years last birthday) <b>71</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>13</b>   |  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bu. of Eng. Govt. Retd.</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Illinois</b>              |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME <b>John B. Irving</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Lillian Frazer</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>None</b>   |  | 17. INFORMANT <b>Allidee Irving Sister</b> Address <b>4523 Middleton Bethesda, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b><br>199.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of face, throat &amp; neck</b><br>DUE TO (c) <b></b><br>INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed 1 yr.</b>                      |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>   |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Frank J. Broschant</b> M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>4-28-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Prince Georges Md</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>4-28-56</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>                   |  |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 1 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4237

CERTIFICATE OF DEATH

Reg. Dist. No.

04215

216

|   |                               |  |                                 |   |   |   |  |
|---|-------------------------------|--|---------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                               |  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |                               |  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5910 Springfield Drive</b>  |                               |  |                                 | d. STREET ADDRESS <b>5910 Springfield Drive</b>   |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>M.</b> Last <b>JACKSON</b>  |                               | 4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1956</b>   |                                 |   |   |   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>12-4-64</b> | 9. AGE (In years last birthday) <b>91</b>   | IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b> |   | IF UNDER 24 HRS. Hours <b></b> Min. <b></b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |                                 | 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                 |  |
| 13. FATHER'S NAME <b>Henry Frey</b>   |                               |  |                                 | 14. MOTHER'S MAIDEN NAME <b>Sarah Crumbling</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>---</b>   |                                 | 17. INFORMANT Address <b>Mrs L. H. Kimmel-Item# 2</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.0 Pulmonary Congestion - Respiratory Failure</b><br>DUE TO <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis Generalized</b><br>DUE TO (c) <b></b> |                               |  |                                 |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>6 yrs</b><br><b>10 yrs.</b>            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               |  |                                 |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I attended the deceased from <b>Aug 1949</b> , 19 <b>56</b> , to <b>4/12/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/12</b> , 19 <b>56</b> , and that death occurred at <b>9:25 PM</b> , from the causes and on the date stated above.  |                               |  |                                 |   |   |   |  |
| ACTUAL SIGNATURE <b>Sherman A. Thomas</b>   |                               |  |                                 | ADDRESS (Street, city or town, state) <b>4301 48th St. N.W. Wash. D.C.</b> DATE SIGNED <b>4/12/56</b>   |   |   |  |
| PHYSICIAN'S NAME (Type) <b>Sherman A. Thomas</b>  |                               |  |                                 | <b>4301 - 48th St., N.W.</b>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>4-16-56</b>   |                                 | 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rose</b>  |   | 22d. LOCATION (City, town, or county) (State) <b>York, Pennsylvania</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey-Bethesda, Md.</b>  |                               |  |                                 | 24a. REC'D BY REGISTRAR DATE <b>4/14/56</b>   |   | 24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>                    |  |

RECEIVED

APR 17 1956



1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04216

# 4238 CERTIFICATE OF DEATH

Reg. Dist. No. 217

|  |                                |   |   |
|--|--------------------------------|---|---|
| <b>1. PLACE OF DEATH</b>   |                                | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                                  |   |
| COUNTY <u>Montgomery</u>   | MARYLAND                       | STATE <u>Maryland</u>   | COUNTY <u>Montgomery</u>  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town)         |   |
| TOWN <u>Olney</u>  | <u>8 days</u>                  | TOWN <u>Silver Spring</u>   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hosp, Inc</u>   |                                | STREET ADDRESS (If rural give location) <u>Route 1, Bonifant Road</u>         |   |
| <b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last)   |                                | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)                                  |   |
| <u>Frederick W. Jenkins, Sr.</u>   |                                | <u>April 26 19 56</u>   |   |
| <b>5. SEX</b>  | <b>6. COLOR OR RACE</b>        | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>                       | <b>8. DATE OF BIRTH</b>   |
| <u>Male</u>  | <u>White</u>                   | <u>Widowed</u>  | <u>4/21/90</u>  |
| <b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>   |                                | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>                                      | <b>11. BIRTHPLACE (State or foreign country)</b>                    |
| <u>PLUMBER</u>   |                                | <u>WASH. GAS CO.</u>  | <u>District of Columbia</u>   |
| <b>13. FATHER'S NAME</b>   |                                | <b>14. MOTHER'S MAIDEN NAME</b>   |   |
| <u>Cyprain Jenkins</u>   |                                | <u>Catherine Ulrich</u>   |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>   |                                | <b>16. SOCIAL SECURITY NO.</b>  | <b>17. INFORMANT &amp; ADDRESS</b>                                  |
| <u>NO</u>  |                                | <u>577-07-7740 A</u>  | <u>Hospital Record</u>  |
| <b>18. MEDICAL CERTIFICATION</b>   |                                |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                             |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                |   |   |
| <u>260x</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>   |                                |   | <u>4 days</u>   |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Distal</u>   |                                |   | <u>years</u>  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                                |   |   |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                |   |   |
| <u>C</u>   |                                |   |   |
| <b>19a. DATE OF OPERATION</b>  |                                | <b>19b. MAJOR FINDINGS OF OPERATION</b>                                       |   |
| <u>L</u>   |                                | <u>C</u>  |   |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                                | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> | <b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b> |
| <input type="checkbox"/>   |                                |   |   |
| <b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>   |                                | <b>21e. INJURY OCCURRED While at work Not while at work</b>                   | <b>21f. HOW DID INJURY OCCUR?</b>                                   |
| <u>M. 4/26/56</u>  |                                | <input type="checkbox"/> <input type="checkbox"/>                             |   |
| <b>22. I hereby certify that I attended the deceased from <u>2/1/56</u>, to <u>4/26/56</u>, that I last saw the deceased alive on <u>4/26/56</u>, and that death occurred at <u>10:20AM</u>, from the causes and on the date stated above.</b> |                                |   |   |
| <b>SIGNATURE</b>   |                                | <b>ADDRESS (Street, city, town, state)</b>                                    | <b>DATE SIGNED</b>  |
| <u>J. M. BIRD</u> (J. M. BIRD) M.D.  |                                | <u>Sandy Sp...</u>  | <u>4/27/56</u>  |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>  | <b>DATE THEREOF</b>            | <b>NAME OF CEMETERY OR CREMATORY</b>  | <b>LOCATION (City, town, or county) (State)</b>                     |
| <u>BURIAL</u>  | <u>4/30/56</u>                 | <u>CEDAR HILL CEMETERY</u>  | <u>PRINCE GEO. CO., MARYLAND</u>                                    |
| <b>24. REC'D BY REGISTRAR</b>  | <b>REGISTRAR'S SIGNATURE</b>   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b>                                       | <b>ADDRESS</b>  |
| <u>4-28-56</u>   | <u>Gertrude B Lawler</u>       | <u>Robert E. Humphrey</u>   | <u>SILVER SPRING, MD.</u>   |

Type Dea's name

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

## 1953 CERTIFICATE OF DEATH

|                          |  |                           |  |                           |  |                           |  |                            |  |                           |  |
|--------------------------|--|---------------------------|--|---------------------------|--|---------------------------|--|----------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED      |  | 2. SEX                    |  | 3. AGE                    |  | 4. RACE                   |  | 5. MARITAL STATUS          |  | 6. OCCUPATION             |  |
| 7. PLACE OF BIRTH        |  | 8. DATE OF BIRTH          |  | 9. PLACE OF DEATH         |  | 10. DATE OF DEATH         |  | 11. TIME OF DEATH          |  | 12. CAUSE OF DEATH        |  |
| 13. MEDICAL HISTORY      |  | 14. PRESENT ILLNESS       |  | 15. TREATMENT             |  | 16. POST-MORTEM           |  | 17. SIGNATURE OF PHYSICIAN |  | 18. SIGNATURE OF DECEASED |  |
| 19. SIGNATURE OF WITNESS |  | 20. SIGNATURE OF DECEASED |  | 21. SIGNATURE OF DECEASED |  | 22. SIGNATURE OF DECEASED |  | 23. SIGNATURE OF DECEASED  |  | 24. SIGNATURE OF DECEASED |  |

**BUREAU V. S.**

MAY 3 1956

**RECEIVED**

ENCLOSURE

4239

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>District of Columbia</b> <b>D.C. COUNTY</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda, Rural</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>2 mo 2 days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lula</b> Middle <b>Mae</b> Last <b>JONES</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>9</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-3-15</b>  |
| 9. AGE (In years last birthday)<br><b>40</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>               | IF UNDER 24 HRS.<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>Tildon V. HORN</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Harriet V. HORN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  |
| 17. INFORMANT<br><b>Husband: John F. JONES MMC USN</b><br><b>Same as item #2</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Leukemia, acute</b><br>204.3<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>7 MONTHS</b> |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>7 Feb</b> , 19 <b>56</b> , to <b>9 Apr</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9 Apr</b> , 19 <b>56</b> , and that death occurred at <b>7:20A</b> M, from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE <b>Willard P. Arentzen</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>USNH, NMMC, Bethesda, Maryland</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Willard P. ARENTZEN CDR, MC, USN</b>  |                                  | DATE SIGNED <b>4-9-56</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                                  | 22b. DATE THEREOF <b>4-11-56</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Lafayette Memorial</b>   |                                  | 22d. LOCATION (City, town, or county) (State) <b>Fayetteville, North Carolina</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>Bethesda, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR <b>4-9-56</b>   |  |
| 24b. REGISTRAR'S SIGNATURE <b>Mary E. Pumphrey</b>   |                                  |   |  |

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

|                        |  |                        |  |                        |  |                       |  |                     |  |                     |  |                       |  |                       |  |                         |  |                      |  |
|------------------------|--|------------------------|--|------------------------|--|-----------------------|--|---------------------|--|---------------------|--|-----------------------|--|-----------------------|--|-------------------------|--|----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                    |  | Date of Birth         |  | Place of Birth      |  | Usual Residence     |  | Cause of Death        |  | Date of Death         |  | Time of Death           |  | Place of Death       |  |
| JAMES V. HENRY         |  | Male                   |  | 40                     |  | 1898                  |  | Maryland            |  | Baltimore, Md.      |  | Heart Disease         |  | April 12, 1956        |  | 10:30 AM                |  | Home                 |  |
| Occupation             |  | Marital Status         |  | Education              |  | Religion              |  | Last Illness        |  | Duration of Illness |  | Attending Physician   |  | Manner of Death       |  | Burial Place            |  | Burial Date          |  |
| None                   |  | Married                |  | High School            |  | Catholic              |  | Heart Failure       |  | 3 Weeks             |  | Dr. J. H. Smith       |  | Natural               |  | St. Mary's Cemetery     |  | April 15, 1956       |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Informant |  | Signature of Deceased |  | Signature of Family |  | Signature of Friend |  | Signature of Neighbor |  | Signature of Minister |  | Signature of Undertaker |  | Signature of Coroner |  |
| J. H. Smith, M.D.      |  | J. H. Smith, M.D.      |  | J. H. Smith, M.D.      |  | J. H. Smith, M.D.     |  | J. H. Smith, M.D.   |  | J. H. Smith, M.D.   |  | J. H. Smith, M.D.     |  | J. H. Smith, M.D.     |  | J. H. Smith, M.D.       |  | J. H. Smith, M.D.    |  |

RECEIVED  
APR 12 1956  
BUREAU V. S.

4240

## CERTIFICATE OF DEATH

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |  | c. LENGTH OF STAY IN 1b<br><b>18 hours</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Richard</b> Middle <b>Joseph</b> Last <b>KAPPRAL</b>   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>3</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2 April 1956</b>                                     |
| 9. AGE (In years last birthday) yrs.<br><b>18</b>  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>18</b> Days <b>18</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Infant</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Bethesda, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas George KAPPRAL</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Christiana A. HARKINS</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Thomas G. KAPPRAL Father,</b>  |  | Address <b>Alexandria, Va.</b><br><b>641 Notabene St.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>762.5</b> <b>Electrocardiogram</b><br>DUE TO <b>Prematurity</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>(b) <b>Prematurity</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>2</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hours</b><br><b>18 hours</b>      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>4-2-56</b> , 19 <b>56</b> , to <b>4-3-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3 April</b> , 19 <b>56</b> , and that death occurred at <b>12:25A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED   |  |  |   |
| ACTUAL SIGNATURE <b>J. W. STOHLMAN, LT, MC, USN</b>  |  | U. S. Naval Hospital, Bethesda, Md.  |   |
| PHYSICIAN'S NAME (Type)<br><b>J. W. STOHLMAN, LT, MC, USN</b>  |  | U. S. Naval Hospital, Bethesda, Md.  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>4-5-56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. A. PUMPHREY</b>  |  | ADDRESS <b>Bethesda, Md.</b><br><b>7557 Wisconsin Ave.,</b>  | 24a. REC'D BY REGISTRAR<br>DATE <b>4-3-56</b>                               |
| 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Passelty</b>  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Figure 1

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U.S. DEPARTMENT OF AGRICULTURE

BUREAU V. S.

APR 6 1956

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4160

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

(If rural, give location)

STREET ADDRESS

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

350x  
Immediate cause

(a) Bronchopneumonia

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Inanition

DUE TO

(c) Parkinson's Disease

INTERVAL BETWEEN ONSET AND DEATH

2 days

3 yrs.

7 yrs.

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Generalized Arteriosclerosis

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11, 1956, to 4/13, 1956, that I last saw the deceased alive on 4/12, 1956, and that death occurred at 12:01 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 17 1956

RECEIVED

4241

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>   |                                  | c. LENGTH OF STAY IN 1b <b>14 hours</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>  |                                  | e. STREET ADDRESS <b>5707 38th street</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>Alexander</b> Last <b>Kennedy</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>16</b> Year <b>19 56</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/5/79</b>  |
| 9. AGE (In years last birthday) <b>76</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>6</b> Hours <b>16</b> Min. <b>56</b>   | IF UNDER 24 HRS.<br>Min. <b>56</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. MAIL CLERK</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. GOV'T.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>David Alexander Kennedy</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Virginia Fox</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  |
| 17. INFORMANT<br><b>Hospital Record</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br><b>4443X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hypertensive cardiovascular disease</b><br>DUE TO<br>(c) _____ |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 hrs.</b><br><b>5 yrs</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I, certify that I attended the deceased from <b>April 15, 1956</b> , to <b>April 16, 1956</b> , that I last saw the deceased alive on <b>April 16, 1956</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE <b>A. D. Bonifant</b>  |                                  | M.D. <b>Sandy Spring, Md</b> DATE SIGNED <b>4/16/56</b>   |  |
| PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M. D.</b>  |                                  | <b>SANDY SPRING, MARYLAND</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>4/19/56</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>GLENWOOD CEMETERY</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON, D.C.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner E. Humphrey</b>   |                                  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>DATE 4-18-56</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Gertrude B Lawler</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





4242

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <b>District of Columbia</b> b. COUNTY                     |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>3 mos 14 days</b>   |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |                                  | 47x-3 ✓   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>   |                                  | d. STREET ADDRESS<br><b>562 Portland St., S.E.</b>  |                                     |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PLACIDE</b> Middle <b>THOMPSON</b> Last <b>KERRICK</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>12</b> Year <b>19 56</b>  |                                     |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-15-86</b> |
| 9. AGE (In years last birthday)<br><b>69</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |                                     |
| 13. FATHER'S NAME<br><b>Oscar THOMPSON</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lucia REDDING</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |                                     |
| 17. INFORMANT<br><b>(Daughter) Mrs. Placide Smyth, South Glen Road.,</b>  |                                  | Address <b>Rockville, Md.</b>   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma, Ovaries with metastases</b><br><b>175x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephritis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2-4 years</b>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>    |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I attended the deceased from <b>Dec. 28</b> , 19 <b>55</b> , to <b>12 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12 April</b> , 19 <b>56</b> , and that death occurred at <b>1:45 P</b> M; from the causes and on the date stated above.  |                                  |   |                                     |
| ACTUAL SIGNATURE<br><b>Jos V Caligiri</b>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>U.S. Naval Hospital, Bethesda, Md. 4-12-56</b>  |                                     |
| PHYSICIAN'S NAME (Type)<br><b>J.V. CALIGIRI, LSPR, MC, USNR</b>   |                                  | <b>U.S. Naval Hospital, Bethesda, Md.</b>   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4-16-56</b>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill, West</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Philadelphia, Penna.</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor &amp; Sons</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>4-12-56</b>   |                                     |
| ADDRESS<br><b>John M. Taylor &amp; Sons, Annapolis, Md</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Parcell</b>  |                                     |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the registrar, director, or funeral director. After this certificate has been signed by the attending physician and completely filled in by the registrar, director, or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>J. Edgar Hoover                     |  | 2. PLACE OF DEATH<br>Baltimore, Md.            |  |
| 3. SEX<br>Male   |  | 4. AGE<br>59                                   |  |
| 5. RACE<br>White   |  | 6. DATE OF DEATH<br>April 16, 1956             |  |
| 7. TIME OF DEATH<br>10:15 AM                               |  | 8. PLACE OF BIRTH<br>Alton, Illinois           |  |
| 9. OCCUPATION<br>Director, Federal Bureau of Investigation |  | 10. CAUSE OF DEATH<br>Myocardial Infarction    |  |
| 11. MANNER OF DEATH<br>Natural                             |  | 12. SIGNATURE OF PHYSICIAN<br>J. Edgar Hoover  |  |
| 13. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 14. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 15. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 16. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 17. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 18. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 19. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 20. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 21. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 22. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 23. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 24. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 25. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 26. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 27. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 28. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 29. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 30. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 31. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 32. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 33. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 34. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 35. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 36. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 37. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 38. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 39. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 40. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 41. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 42. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 43. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 44. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 45. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 46. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 47. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 48. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 49. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 50. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 51. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 52. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 53. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 54. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 55. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 56. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 57. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 58. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 59. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 60. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 61. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 62. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 63. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 64. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 65. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 66. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 67. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 68. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 69. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 70. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 71. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 72. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 73. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 74. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 75. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 76. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 77. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 78. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 79. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 80. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 81. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 82. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 83. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 84. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 85. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 86. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 87. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 88. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 89. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 90. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 91. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 92. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 93. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 94. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 95. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 96. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 97. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 98. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 99. SIGNATURE OF DECEASED<br>J. Edgar Hoover               |  | 100. SIGNATURE OF WITNESSES<br>J. Edgar Hoover |  |

BUREAU V. 8

APR 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04222  
Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>                    |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville - city 13</u>  |  | c. LENGTH OF STAY IN 1b<br><u>4 yrs</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville - city 13</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Sycamore Acres</u>   |  |   |  | d. STREET ADDRESS<br><u>Sycamore Acres</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Vernon</u> Middle <u>Dorman</u> Last <u>King Sr.</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>8</u> Year <u>1956</u>  |  |   |  |
| 5. SEX<br><u>male</u>   |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1-13-42</u>  |  |
| 9. AGE (In years last birthday)<br><u>42</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bricklayer</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Bricklayer</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>Lawrence King</u>   |  |   |  | 14. MOTHER'S M maiden NAME<br><u>Mabel</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>218-18-8569</u>   |  | 17. INFORMANT<br><u>Oliver King (wife)</u> Address <u>same as dec'd</u>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>42011 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u><br>DUE TO (c) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>Found dead in bed</u>  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>  </u>   |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>   |  | 20f. (City or town) (County) (State)<br><u>  </u>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>4/11/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>PARKLAWN CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>MONTGOMERY COUNTY, MARYLAND</u>               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Walter E. Humphrey</u>   |  |   |  | ADDRESS<br><u>SILVER SPRING, MD.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>4/11/56</u>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Laurel H. Hagtop</u>   |  |   |  |

BUREAU V. S.

APR 12 1956

REVISED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4161

## CERTIFICATE OF DEATH

04223

Reg. Dist. No.

223

|  |                               |  |                                 |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>         |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>   |                                 |
| c. LENGTH OF STAY IN 1b <u>68 days</u>   |                               | d. STREET ADDRESS <u>4201 Van Buren St.</u>  |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |
| 3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Thelma V. Kushner</u> Middle <u>Thelma V. Kushner</u> Last   |                               | 4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1956</u>   |                                 |
| 5. SEX <u>female</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-26-92</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs.   |                               | IF UNDER 1 YEAR Months Days Hours Min.   |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                 |
| 13. FATHER'S NAME <u>Harris Venezky</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Rebecca Domish</u>   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO.  |                                 |
| 17. INFORMANT <u>Wash. San + Hosp Records - Son.</u>   |                               | Address  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Perforation of Stomach - Peritonitis</u><br>196X DUE TO <u>irradiation effect for</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Giant Cell Sarcoma of Vertebra</u><br>DUE TO <u>Primary in left femur</u><br>(c) <u>Healed Rheumatic Carditis - Carcinoma of uterus</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u><br><u>1 year</u><br><u>5 yrs</u>  |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>47</u> , to <u>4/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>56</u> , and that death occurred at <u>1:25 P.M.</u> , from the causes and on the date stated above.  |                               |  |                                 |
| ACTUAL SIGNATURE <u>Cecile L. Fusfeld M.D.</u>   |                               | DATE SIGNED <u>4/30/56</u>   |                                 |
| PHYSICIAN'S NAME (Type)  |                               | ADDRESS (Street, city or town, state)  |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                               | 22b. DATE THEREOF <u>5/1/56</u>  |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <u>West Capt. John A.</u>   |                               | 22d. LOCATION (City, town, or county) (State)  |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Blumenfeld</u>   |                               | ADDRESS <u>3501-14th St N.W. Wash D.C.</u>   |                                 |
| 24a. REC'D BY REGISTRAR <u>5/2/56</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>J. H. H. H.</u>  |                                 |



BUREAU V. 3

MAY 3 1956

RECEIVED

*[Faint, illegible text from bleed-through]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, case examine the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04224

Reg. Dist. No. 223

|   |                              |   |                                   |   |                                |   |  |
|---|------------------------------|---|-----------------------------------|---|--------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND   |                              |   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md</u> b. COUNTY <u>Montg.</u> |                                |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |                              | c. LENGTH OF STAY IN lb<br><u>life</u>  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>                              |                                |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>54 Walnut AVE.</u>   |                              |   |                                   | d. STREET ADDRESS<br><u>54 Walnut AVE.</u>  |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Eugene</u> Middle <u>Ray</u> Last <u>Lane</u>   |                              |   |                                   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>1</u> Year <u>1958</u>  |                                |   |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1/2/07</u> | 9. AGE (In years)<br><u>49</u> yrs.   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>plumber-contractor</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>GLN PLUMBING</u>  |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>TOPEKA, KANSAS</u>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>WILLIAM R. LANE</u>   |                              |   |                                   | 14. MOTHER'S MAIDEN NAME<br><u>GERTRUDE FARMAN</u>  |                                |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, so far unknown) <u>YES</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>100-11-577-26-9593</u>  |                                   | 17. INFORMANT<br>Address <u>MRS. SADIE L. WARD - 714 QUACKENBOS ST. NW WASH. DC.</u>  |                                |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br><u>973.1</u> DUE TO <u>Carbon monoxide poisoning</u><br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(c), stating the underlying cause lost. DUE TO _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                              |   |                                   |   |                                | INTERVAL BETWEEN ONSET AND DEATH<br><u>Found dead in auto</u>                                     |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>hose attached from exhaust to window of car</u>          |                                   |   |                                |   |  |
| 20c. TIME OF INJURY<br>Hour <u>?</u> o. m. <u>4/1/56</u> p. m.  |                              | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>home</u>   |                                | 20f. (City or town) (County) (State)<br><u>Takoma Pk. Montg. Md.</u>                              |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .                                |                              |   |                                   |   |                                |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.   |                              |   |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                |   |  |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>  |                              |   |                                   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                |   |  |
|   |                              |   |                                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>APRIL 4, 1958</u>   |                              | 22b. DATE THEREOF   |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>ARLINGTON NAT'L CEM.</u>   |                                | 22d. LOCATION (City, town, or county) (State)<br><u>ARLINGTON VA.</u>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John S. Hickey</u>   |                              |   |                                   | 24a. REC'D BY REGISTRAR<br>DATE <u>4-3-58</u>   |                                | 24b. REGISTRAR'S SIGNATURE<br><u>John S. Hickey</u>   |  |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Michael R. Kane  
 Gerardo Larkin

BUREAU V. S.

APR 5 1956

RECEIVED

1956  
 April 19  
 Michael R. Kane  
 Gerardo Larkin  
 124 Carroll Station  
 Baltimore, Md. 21202

## CERTIFICATE OF DEATH

04225

Reg. Dist. No. 277

4244

|  |                           |  |  |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clney</u>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co Cent Hosp Inc</u>  |                           | d. STREET ADDRESS <u>12001 Colesville Rd</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Charles S. LAWRENSON</u>  |                           | 4. DATE OF DEATH <u>April 8</u> 19 <u>60</u>   |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 30 - 1896</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs.   |                           | IF UNDER 1 YEAR: Months <u>8</u> Days <u>9</u> Hours <u>19</u> Min. <u>6</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPRESENTATIVE OF REAL ESTATE COMMISSION</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>STATE OF MARYLAND</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Harvey M. LAWRENSON</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Julia E King</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>#1 and #2</u>  |                           | 16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>  |  |
| 17. INFORMANT <u>MRS. BERNICE M. LAWRENSON</u>   |                           | Address <u>12,001 Colesville Rd.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u><br>DUE TO (b) <u>Chronic degenerative</u><br>DUE TO (c) <u>lying cause lost.</u>                                  |                           | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u><br><u>12 yrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19 <u>56</u>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>April 8</u> , 19 <u>56</u> , to <u>April 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>56</u> , and that death occurred at <u>9:40 P</u> M, from the causes and on the date stated above. |                           |  |  |
| ACTUAL SIGNATURE <u>[Signature]</u>  |                           | ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u>  |  |
| PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>  |                           | DATE SIGNED <u>4/8/56</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                           | 22b. DATE THEREOF <u>4/11/56</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>   |                           | 22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>   |                           | ADDRESS <u>SILVER SPRING, MARYLAND</u>   |  |
| 24a. REC'D BY REGISTRAR <u>DATE 4-10-56</u>  |                           | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is divided into several horizontal sections with labels for each field.

BUREAU V. 3

APR 13 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4245

## CERTIFICATE OF DEATH

04226  
Reg. Dist. No. 2/6

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b><br><b>National Institutes of Health</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda, Maryland</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | d. STREET ADDRESS<br><b>3 Pooks Hill Road, Apt 704</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ruth</b> Middle <b>Stewart</b> Last <b>LeClaire</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>10</b> Year <b>19 56</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 6, 1891</b>   |  |
| 9. AGE (In years last birthday) <b>65</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>John Eaton</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Nelissa Uhls</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  |  |  |
| 17. INFORMANT<br><b>The medical record Nat'l Inst. of Health</b><br><b>The Clinical Center Bethesda, Md.</b>  |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic Cancer</b><br>DUE TO <b>Breast Carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 1/2 yrs</b><br>(c) |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Electrolyte Imbalance</b>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. ft. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)               |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>April 9</b> , 19 <b>56</b> , to <b>April 10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 10</b> , 19 <b>56</b> , and that death occurred at <b>5:55 PM</b> , from the causes and on the date stated above.                                      |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Arnold Flick, M.D.</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>The Clinical Center</b><br><b>National Institutes of Health</b><br><b>Bethesda, Md.</b>                         |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Arnold Flick, M. D.</b>  |  |   |  | DATE SIGNED <b>4/11/56</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF                         |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)  |  |
| <b>Burial-Transit 4-12-56</b>   |  | <b>4-12-56</b>                            |  | <b>Riverview Abbey</b>   |  | <b>Portland, Oregon</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 4/14/56</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b><br><i>Bessie M. Thompson</i> |  |

CERTIFICATE OF DEATH

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br><i>John A. Smith</i>        |  | 2. SEX<br><i>Male</i>                              |  | 3. AGE<br><i>45</i>                                |  |
| 4. DATE OF DEATH<br><i>April 6, 1951</i>           |  | 5. TIME OF DEATH<br><i>10:30 AM</i>                |  | 6. PLACE OF DEATH<br><i>Home</i>                   |  |
| 7. CAUSE OF DEATH<br><i>Myocardial Infarction</i>  |  | 8. MANNER OF DEATH<br><i>Natural</i>               |  | 9. PLACE OF BIRTH<br><i>St. Louis, Mo.</i>         |  |
| 10. OCCUPATION<br><i>Engineer</i>                  |  | 11. MARITAL STATUS<br><i>Married</i>               |  | 12. EDUCATION<br><i>High School</i>                |  |
| 13. PREVIOUS ILLNESS<br><i>None</i>                |  | 14. MEDICAL HISTORY<br><i>None</i>                 |  | 15. SURVIVAL OF OTHERS<br><i>None</i>              |  |
| 16. SIGNATURE OF PHYSICIAN<br><i>John A. Smith</i> |  | 17. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 18. SIGNATURE OF WITNESSES<br><i>John A. Smith</i> |  |
| 19. SIGNATURE OF REGISTRAR<br><i>John A. Smith</i> |  | 20. SIGNATURE OF CLERK<br><i>John A. Smith</i>     |  | 21. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 22. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 23. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 24. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 25. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 26. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 27. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 28. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 29. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 30. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 31. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 32. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 33. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 34. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 35. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 36. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 37. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 38. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 39. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 40. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 41. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 42. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 43. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 44. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 45. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 46. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 47. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 48. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 49. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 50. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 51. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 52. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 53. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 54. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 55. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 56. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 57. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
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| 73. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 74. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 75. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 76. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 77. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 78. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 79. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 80. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 81. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 82. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 83. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 84. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 85. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 86. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 87. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 88. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 89. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 90. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 91. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 92. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 93. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 94. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 95. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 96. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 97. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 98. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 99. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 100. SIGNATURE OF DECEASED<br><i>John A. Smith</i> |  | 101. SIGNATURE OF DECEASED<br><i>John A. Smith</i> |  | 102. SIGNATURE OF DECEASED<br><i>John A. Smith</i> |  |

RECEIVED  
BUREAU V. S.  
APR 17 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4246

## CERTIFICATE OF DEATH

0422516  
Reg. Dist. No.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>  |  |   |  |
| c. LENGTH OF STAY IN 1b <u>3 days</u>   |  |  |  | d. STREET ADDRESS <u>3501 Shepherd St.</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Robert Crockett</u> First <u>Lester</u> Middle <u>Lester</u> Last  |  |  |  | 4. DATE OF DEATH <u>April</u> Month <u>10</u> Day <u>1956</u> Year   |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Nov. 9, 1881</u>  |  |
| 9. AGE (In years last birthday) <u>74</u> yrs.  |  | IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.                            |  | IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor Organizer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery &amp; Sales</u>                                  |  | 11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Robert Crockett Lester</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Gingell</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)                               |  | 17. INFORMANT <u>Wife. Mary H. Lester - same as above</u> Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>DUE TO <u>154X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of rectosigmoid Colon</u><br>DUE TO <u>2 years</u><br>(c) |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suppuration Rt</u>   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m.   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |  |  |   |  |
| 21. I certify that I attended the deceased from <u>October, 1954</u> to <u>April 10, 1956</u> that I last saw the deceased alive on <u>April 9, 1956</u> , and that death occurred at <u>125 AM</u> , from the causes and on the date stated above.   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3921 Ragsman St NW</u> <u>3/11/56</u>   |  |  |  | DATE SIGNED <u>3/11/56</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u>  |  |  |  | <u>re ash. &amp; B.</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>4-13-56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey-Bethesda, Md.</u> ADDRESS   |  |  |  | 24a. REC'D BY REGISTRAR <u>DATE 4/14/56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Basim Thompson</u><br><u>Reg. Dist.</u>   |  |

CERTIFICATE OF DEATH

1956

|  |  |   |  |  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED<br>[Faint text]        |  | 2. SEX<br>[Faint text]                    |  | 3. AGE<br>[Faint text]                   |  | 4. DATE OF BIRTH<br>[Faint text]          |  | 5. PLACE OF BIRTH<br>[Faint text]        |  | 6. OCCUPATION<br>[Faint text]              |  |
| 7. MARITAL STATUS<br>[Faint text]          |  | 8. RACE<br>[Faint text]                   |  | 9. COLOR<br>[Faint text]                 |  | 10. RELIGION<br>[Faint text]              |  | 11. EDUCATION<br>[Faint text]            |  | 12. SOCIAL SECURITY NUMBER<br>[Faint text] |  |
| 13. DATE OF DEATH<br>[Faint text]          |  | 14. TIME OF DEATH<br>[Faint text]         |  | 15. PLACE OF DEATH<br>[Faint text]       |  | 16. CAUSE OF DEATH<br>[Faint text]        |  | 17. MANNER OF DEATH<br>[Faint text]      |  | 18. SIGNATURE OF PHYSICIAN<br>[Faint text] |  |
| 19. SIGNATURE OF REGISTRAR<br>[Faint text] |  | 20. SIGNATURE OF DECEASED<br>[Faint text] |  | 21. SIGNATURE OF WITNESS<br>[Faint text] |  | 22. SIGNATURE OF DECEASED<br>[Faint text] |  | 23. SIGNATURE OF WITNESS<br>[Faint text] |  | 24. SIGNATURE OF DECEASED<br>[Faint text]  |  |

BUREAU V. S.

APR 17 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18  
1956  
RECEIVED  
APR 17 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4247

## CERTIFICATE OF DEATH

Reg. Dist. No. **042287**

|   |  |   |  |   |   |   |   |
|---|--|---|--|---|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Olney</u>  |  |   | c. LENGTH OF STAY IN 1b<br><u>10 hours</u> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sandy Spring</u> |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Montgomery County General Hospital</u>   |  |   |  | d. STREET ADDRESS<br>/  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Lethbridge</u>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>April</u> Day <u>4</u> Year <u>19 56</u>  |   |   |   |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                             |   | 8. DATE OF BIRTH<br><u>11/10/74</u>   |   |
| 9. AGE (In years last birthday)<br><u>81</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |   |
| 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |   |
| 13. FATHER'S NAME<br><u>Owen Disney</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Elizabeth Johnson</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>If yes, give war or dates of service  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Hospital Record</u>   |   |   |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocarditis</u><br>DUE TO (b) <u>Arterio Sclerosis</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u><br><u>11</u>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Arthritis Multiple</u>  |  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>✓</u>  |  |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>3/1/1952</u> to <u>4/4/1956</u> that I last saw the deceased alive on <u>4/4/1956</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Sandy Spring</u> DATE SIGNED <u>4/5/56</u><br>ACTUAL SIGNATURE <u>J. W. Bird</u> M.D. PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u> |  |   |  |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>APRIL 7 1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>BURTONSVILLE</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>HOWAR CO</u> <u>MD</u>                                      |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Roy W. Barber</u>  |  |   |  | ADDRESS<br><u>Raytonville</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>4-6-56</u>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Bertina B. Lawler</u>  |  |   |  |   |   |   |   |

MEDICAL CERTIFICATION

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                                      |  |                       |  |
|--------------------------------------|--|-----------------------|--|
| PLACE IN REVERSE OF THIS CERTIFICATE |  | DATE OF DEATH         |  |
| NAME OF DECEASED                     |  | AGE                   |  |
| SEX                                  |  | RACE                  |  |
| PLACE OF BIRTH                       |  | PLACE OF DEATH        |  |
| DATE OF BIRTH                        |  | DATE OF DEATH         |  |
| TIME OF DEATH                        |  | CAUSE OF DEATH        |  |
| MANNER OF DEATH                      |  | PLACE OF INTERMENT    |  |
| SIGNATURE OF REGISTRAR               |  | SIGNATURE OF DECEASED |  |
| DATE OF REGISTRATION                 |  | DATE OF DEATH         |  |

BUREAU V. 3

APR 10 1956

RECEIVED

APR 7 1956  
BUREAU OF VITALS  
BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04229

4163

## CERTIFICATE OF DEATH

Reg. Dist. No.

123

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  | c. LENGTH OF STAY IN TB <u>2 1/2 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> ✓                                 |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>  |  |   |  | d. STREET ADDRESS <u>2616 Lamont St. N.W.</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>NO</u> Last <u>Liff</u>   |  | 4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>  |  | 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>white</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH  |  | 9. AGE (in years last birthday) <u>80</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Russia</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Isaac Liff</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |  | 17. INFORMANT <u>Hospital Records</u>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bladder Neck Obstruction</u><br>DUE TO (c) <u>Prostatic Hypertrophy</u> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Apr. 10., 1956</u> , to <u>April 24, 1956</u> , that I last saw the deceased alive on <u>April 24</u> , 1956, and that death occurred at <u>11:30 p. M.</u> from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Arthur S. Bresler</u>   |  | M.D. <u>533 Riggs Rd, N.E.</u>  |  | ADDRESS (Street, city or town, state) <u>Washington, D.C.</u>  |  | DATE SIGNED <u>4-24-56</u>   |  |
| PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER</u>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>4/26/56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Eisenhower</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Congress Heights, D.C.</u>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>10 Sanyaneky 9 St</u>   |  | ADDRESS <u>3501-14th St NW</u>  |  | 24a. REC'D BY REGISTRAR <u>DATE 4-27-56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u>   |  |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

BUREAU V. S.

APR 30 1956

RECEIVED

4164

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

|  |                               |  |                                   |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>—</u> b. COUNTY <u>47X-3</u>                        |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |                               | c. LENGTH OF STAY IN 1b <u>5 mos - 5 days</u>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Sumner</u> Last <u>Lobingier</u>  |                               | 4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1956</u>   |                                   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-30-1866</u> |
| 9. AGE (In years last birthday) <u>89</u> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>Illinois</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>   |                                   |
| 13. FATHER'S NAME <u>George Lobingier</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Ada Stewart</u>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>Hosp. Records</u>   |                                   |
| 17. INFORMANT Address  |                               |  |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>180X</u> <u>Wernia</u><br>DUE TO <u>Carcinoma of kidney</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u><br><u>1 year?</u>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart failure - Generalized arteriosclerosis</u>   |                               |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>55</u> , to <u>April 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>56</u> , and that death occurred at <u>4:42 P.M.</u> , from the causes and on the date stated above.  |                               |  |                                   |
| ACTUAL SIGNATURE <u>J. W. Whitlock</u>   |                               | ADDRESS (Street, city or town, state) <u>Washington San Hosp Takoma Park Md</u>  |                                   |
| PHYSICIAN'S NAME (Type) <u>J. W. Whitlock</u>  |                               | DATE SIGNED <u>4/29/56</u>   |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>4/30/56</u>   |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>  |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion W. Hyman</u>  |                               | ADDRESS <u>1300 N St NW</u>  |                                   |
| 24a. REC'D BY REGISTRAR <u>J. W. Whitlock</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>J. W. Whitlock</u>   |                                   |
| DATE <u>4/29/56</u>  |                               |  |                                   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7/30/75 (over) H21

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BUREAU V. S.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4248

## CERTIFICATE OF DEATH

04231

Reg. Dist. No. 216

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Rural-Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-Bethesda</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>RFD # 3 Bethesda</b>   |  |   |  | d. STREET ADDRESS<br><b>RFD # 3 Bethesda</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   |
| 3. NAME OF DECEASED (Type or print)<br><b>JAMES MACKIN LYNCH</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>18</b> Year <b>1956</b>  |  |   |   |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12-9-89</b>  |   |
| 9. AGE (In years last birthday) yrs. <b>66</b>  |  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>9</b>                              |  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Never Employed</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
|   |  |   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John W. Lynch</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lucinder Robert Conley</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>None</b> |  | 17. INFORMANT Address<br><b>Paul Conley-Item # 2</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Acute Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac Decompensation</b><br>(c) <b>Advanced Arteriosclerosis</b> |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>2 months</b><br><b>6 years</b>          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                    |   |
|   |  |   |  | 20f. (City or town)  |  | (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>4/17/56</b> , 19 <b>56</b> , to <b>4/18/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/17/56</b> , 19 <b>56</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above.  |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>Frank Jagers</b>   |  |   |  | ADDRESS (Street, city or town, state)<br><b>5707 Wisconsin Ave</b>   |  |   |   |
| PHYSICIAN'S NAME (Type)<br><b>FRANK JAGGERS</b>   |  |   |  | DATE SIGNED<br><b>4/18/56</b>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |  | 22b. DATE THEREOF<br><b>4-20-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Gabriels</b>   |   |
|   |  |   |  |  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Potomac, Maryland</b>                                 |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>4/21/56</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Bennie M. Thompson</b>   |   |

BUREAU V. S.

APR 23 1956

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BUREAU V. S.

APR 10 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04233

4250

## CERTIFICATE OF DEATH

Reg. Dist. No.

213

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>District of Columbia</b> b. COUNTY                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>20 days</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |                                  | 47X-3 ✓  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda, Md.</b>   |                                  | d. STREET ADDRESS<br><b>1333 Columbia Road, N. W.</b>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lumanda</b> Middle <b>(no middle name)</b> Last <b>Massey</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>4</b> Year <b>1956</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 4, 1917</b>                               |
| 9. AGE (In years last birthday)<br><b>38</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <b>38</b> Days <b>0</b> Hours <b>0</b> Min.  | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housework</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Joseph Massey</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lula Dickerson</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>not available</b>   |   |
| 17. INFORMANT<br><b>The Medical Record</b>  |                                  | Address<br><b>The Clinical Center, Bethesda, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Autostatic carcinoma of breast</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>March 15, 1956</b> , to <b>April 4, 1956</b> , that I last saw the deceased alive on <b>April 4, 1956</b> and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE<br><b>Arthur G. Ship</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center<br/>National Institutes of Health<br/>Bethesda 14, Maryland</b>                          |   |
| PHYSICIAN'S NAME (Type)<br><b>Arthur G. Ship, M. D.</b>   |                                  | DATE SIGNED<br><b>4/5/56</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4-9-56</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON, D.C.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John T. Rhines &amp; Co.</b>   |                                  | ADDRESS<br><b>901 3rd St. S.W.</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>APR 9 1956</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Kanelly</b>   |   |



# CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE 12

|                        |  |             |  |                     |  |                   |  |               |  |                     |  |
|------------------------|--|-------------|--|---------------------|--|-------------------|--|---------------|--|---------------------|--|
| NAME OF DECEASED       |  | AGE         |  | SEX                 |  | RACE              |  | DATE OF BIRTH |  | PLACE OF BIRTH      |  |
| JOSEPH A. HENRY        |  | 70          |  | M                   |  | W                 |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| MARRIAGE               |  | DATE        |  | PLACE               |  | NAME OF SPouse    |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| MARRIED                |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| OCCUPATION             |  | DATE        |  | PLACE               |  | NAME OF EMPLOYER  |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| RETIRED                |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| EDUCATION              |  | DATE        |  | PLACE               |  | NAME OF SCHOOL    |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| HIGH SCHOOL            |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| RELIGION               |  | DATE        |  | PLACE               |  | NAME OF CHURCH    |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| CATHOLIC               |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| CAUSE OF DEATH         |  | DATE        |  | PLACE               |  | NAME OF PHYSICIAN |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| HEART DISEASE          |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| MANNER OF DEATH        |  | DATE        |  | PLACE               |  | NAME OF PHYSICIAN |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| NATURAL                |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| SIGNATURE OF PHYSICIAN |  | DATE        |  | PLACE               |  | NAME OF PHYSICIAN |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| JOSEPH A. HENRY        |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |
| SIGNATURE OF REGISTRAR |  | DATE        |  | PLACE               |  | NAME OF REGISTRAR |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| JOSEPH A. HENRY        |  | APR 10 1956 |  | BALTIMORE, MARYLAND |  | JOSEPH A. HENRY   |  | APR 10 1956   |  | BALTIMORE, MARYLAND |  |

BUREAU V. 3

APR 10 1956

RECEIVED

4251

## CERTIFICATE OF DEATH

Reg. Dist. No.

215

|   |                                  |   |                                   |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>District of Columbia</b> b. COUNTY                  |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda Rural</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1 mo 1 day</b>  |                                   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b>   |                                  | 472-3   |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |                                  | d. STREET ADDRESS<br><b>1219 Michigan Avenue, N.E.</b>  |                                   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anna</b> Middle <b>Margaret</b> Last <b>MAURER</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>15</b> Year <b>19 56</b>  |                                   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            | 8. DATE OF BIRTH<br><b>6-9-90</b> |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |                                   |
| 13. FATHER'S NAME<br><b>Michael FREBERT</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine VOIT</b>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |                                   |
| 17. INFORMANT<br><b>husband Mr. Gustav MAURER</b> Address<br><b>Same as item #2</b>   |                                  |   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of stomach</b><br>DUE TO (b) <b>Indefinite</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that I attended the deceased from <b>13 March</b> , 19 <b>56</b> , to <b>15 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>15 April</b> , 19 <b>56</b> , and that death occurred at <b>1:00P</b> M, from the causes and on the date stated above.                          |                                  |   |                                   |
| ACTUAL SIGNATURE <b>W. H. Howell</b>  |                                  | M.D. <b>USNH, NNMC, Bethesda, Maryland</b> DATE SIGNED <b>4-16-56</b>   |                                   |
| PHYSICIAN'S NAME (Type) <b>W. H. HOWELL, LCDR, MC, USN</b>  |                                  | <b>USNH, NNMC, Bethesda, Maryland</b>   |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>18 Apr 56</b>   |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Marys Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b>  |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S. J. This Co.</b>   |                                  | ADDRESS<br><b>Hines Funeral Home</b><br><b>2901 14th Street, Wash D.C.</b>  |                                   |
| 24a. REC'D BY REGISTRAR<br><b>DATE 15 Apr 56</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Russell</b>  |                                   |

MEDICAL CERTIFICATION

2

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 5234

APR 18 1956

RECEIVED

4252

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D. C.</u> b. COUNTY                                    |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington, D.C.</u> 47X-3   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>74 Suburban</u>  |  |   |  | d. STREET ADDRESS<br><u>813 Juniper St. N. W.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Louise</u> Middle <u>Plato</u> Last <u>McCarrick</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>4</u> Year <u>1956</u>  |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9/23/82</u>  |  |
| 9. AGE (In years lost birthday) yrs.<br><u>73</u>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired - Clerk</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>U. S. Gov't.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Pittsburg, Pa.</u>              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>Charles Harvey</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>YES</u>   |  | 17. INFORMANT<br><u>Edna Plato, daughter, 813 Juniper St., N.W.</u>             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u><br>DUE TO <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u><br>(b) <u>Arteriosclerosis</u><br>DUE TO <u>Arteriosclerosis</u><br>(c) <u>Arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>1-2 days</u><br><u>7</u> |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <u>1944</u> to <u>4 April, 1956</u> that I last saw the deceased alive on <u>4 April, 1956</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>9006 Colesville Rd., Silver Spring, Md.</u> DATE SIGNED <u>William D. Aud</u>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>William D. Aud</u> M.D. <u>9006 Colesville Rd., Silver Spring, Md.</u>  |  |   |  | PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u> <u>9006 Colesville Rd., Silver Spring, Md.</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>4/6/56</u>        |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>FT. LINCOLN CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>PRINCE GEO. COUNTY, MD.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>4/7/56</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Bessie M. Thompson</u>                         |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the funeral director. Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4258 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04236  
Reg. Dist. No. 276

|   |                                  |  |  |   |                                     |   |   |                |
|---|----------------------------------|--|--|---|-------------------------------------|---|---|----------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |                                     |   |   |                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase,</b>   |                                  | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>4208 Leland Street</b>   |                                  |  |  | d. STREET ADDRESS<br><b>4208 Leland Street</b>  |                                     |   |   |                |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>JANIE SMITH McCORKLE</b>  |                                  |  |  | 4. DATE OF DEATH Month Day Year<br><b>April 30, 19 56</b>   |                                     |   |   |                |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> | 8. DATE OF BIRTH<br><b>June 23, 1877</b> | 9. AGE (In years last birthday)<br><b>78 yrs.</b>   | IF UNDER 1 YEAR<br><b>10 Months</b> | IF UNDER 24 HRS.<br><b>Days Hours Min.</b>  |   |                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |                |
| 13. FATHER'S NAME<br><b>John Smith</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Marshall</b>  |                                     |   |   |                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates at service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>No</b>   |  | 17. INFORMANT Address<br><b>Arthur Wood-Item # 2</b>  |                                     |   |   |                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>  |                                  |  |  |   |                                     |   |   |                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |   |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |                                     |   |   |                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |   |                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |  |  |   |                                     |   |   |                |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b>  |                                  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                     |   |   | DATE SIGNED    |
| EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>  |                                  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                     |   |   | <b>4-30-56</b> |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  |  |  |   |                                     |   |   |                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>5-2-56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill</b>  |                                     | 22d. LOCATION (City, town, or county) (State)<br><b>Lynchburg, Virginia</b>                       |   |                |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Robert A. Pumphrey-Bethesda, Maryland</b>  |                                  |  |  | 24a. REC'D BY REGISTRAR<br><b>DATE 4/30/56</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Bernie M. Thompson</b>   |   |                |

BUREAU V. S.

MAY 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4254

## CERTIFICATE OF DEATH

Reg. Dist. No.

04237

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>West Virginia</b> b. COUNTY <b>--</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>20 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, National Institutes of Health</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Beckley</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dorothy</b> Middle <b>Viola</b> Last <b>McCullough</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>17</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 27, 1914</b> |
| 9. AGE (In years last birthday) yrs. <b>42</b>   |                                  | IF UNDER 1 YEAR Months Days Hours Min. <b>42</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Circulation Clerk</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Howard McCullough</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elsie Long</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>234-10-7063</b>  |   |
| 17. INFORMANT<br><b>The medical record</b>   |                                  | Address <b>Nat'l Inst of Health Bethesda, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410X Multiple pulmonary infarctions - found at autopsy</b><br>DUE TO (b) <b>Post operative mitral &amp; Aortic Commissurotomy</b><br>DUE TO (c) <b>Rheumatic Heart Disease, Mitral &amp; Aortic Stenosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>instantaneously</b><br><b>6 days</b><br><b>37 yrs.</b>                  |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>March 28</b> , 19 <b>56</b> , to <b>April 17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 17</b> , 19 <b>56</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED<br><b>The Clinical Center</b><br><b>National Institutes of Health</b><br><b>Bethesda, Maryland</b><br><b>4/18/56</b> |                                  |  |   |
| ACTUAL SIGNATURE<br><b>Edward H. Sharp</b>   |                                  | M.D.<br><b>Edward H. Sharp, M. D.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Edward H. Sharp, M. D.</b>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 22b. DATE THEREOF<br><b>4-18-56</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Beckley, W. Va.</b>   |                                  | 22d. LOCATION (City, town, or county) (State)  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Maryland</b>   |                                  | ADDRESS<br><b>Beckley, W. Va.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>DATE 4-18-56</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b>  |   |

CERTIFICATE OF DEATH

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| NAME OF DECEASED<br>MARY ANN WATKINS    |  | SEX<br>FEMALE                                |  | AGE<br>67 YEARS   |  |
| PLACE OF BIRTH<br>BALTIMORE, MARYLAND   |  | DATE OF BIRTH<br>MARCH 27, 1871              |  | PLACE OF DEATH<br>BALTIMORE, MARYLAND                     |  |
| OCCUPATION<br>HOUSEWIFE                 |  | CAUSE OF DEATH<br>HEART DISEASE              |  | MANNER OF DEATH<br>NATURAL                                |  |
| DATE OF DEATH<br>APRIL 1, 1956          |  | TIME OF DEATH<br>10:30 A.M.                  |  | PLACE OF INTERMENT<br>GREENMOUNT CEMETERY, BALTIMORE, MD. |  |
| NAME OF PHYSICIAN<br>DR. J. H. WATKINS  |  | NAME OF FUNERAL HOME<br>WATKINS FUNERAL HOME |  | NAME OF UNDERTAKER<br>WATKINS FUNERAL HOME                |  |
| NAME OF NEXT OF KIN<br>J. H. WATKINS    |  | NAME OF MINISTER<br>REV. J. H. WATKINS       |  | NAME OF CHURCH<br>ST. JAMES' CHURCH                       |  |
| NAME OF CEMETERY<br>GREENMOUNT CEMETERY |  | NAME OF INTERMENT<br>INTERMENT               |  | NAME OF BURIAL<br>BURIAL                                  |  |

BUREAU V. S.

APR 20 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4255

## CERTIFICATE OF DEATH

04238

Reg. Dist. No.

|   |                           |  |                                  |
|---|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montg.</u>                |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>  |                           | c. LENGTH OF STAY IN 1b <u>3 days</u>  |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 3. NAME OF DECEASED (Type or print) <u>Kim</u> First <u>Lizabeth</u> Middle <u>BABY GIRL</u> Last <u>McFARLAND</u>  |                           | 4. DATE OF DEATH <u>4</u> Month <u>7</u> Day <u>1956</u> Year  |                                  |
| 5. SEX <u>Fe</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4 Apr 56</u> |
| 9. AGE (In years last birthday) yrs. <u>3</u>   |                           | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Non-apphc</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Nonapphc</u>  |                                  |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                  |
| 13. FATHER'S NAME <u>STANLEY J. JR</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>NANCY W. WRIGHT</u>  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>   |                           | 16. SOCIAL SECURITY NO. <u>—</u>   |                                  |
| 17. INFORMANT <u>MOTHER</u>   |                           | Address <u>1906 ROCKLAND Ave</u>   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sustained Shock</u><br>DUE TO <u>760.0</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Subdural hemorrhage + rt. Adrenal</u><br>DUE TO <u>Birth Trauma</u><br>(c) <u>Birth Trauma</u> |                           | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>   |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I attended the deceased from <u>4 Apr 1956</u> , to <u>7 Apr 1956</u> , that I last saw the deceased alive on <u>6 Apr 1956</u> , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.  |                           |  |                                  |
| ACTUAL SIGNATURE <u>Francis J Troendle</u> M.D.   |                           | ADDRESS (Street, city or town, state) <u>809 VIERS MILL RD ROCKVILLE</u>   |                                  |
| PHYSICIAN'S NAME (Type) <u>FRANCIS J TROENDLE MD</u>  |                           | DATE SIGNED <u>7 APR 1956</u>  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>Apr 9 1956</u>  |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>  |                           | 22d. LOCATION (City, town, or county) (State) <u>Rockville Md</u>  |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Lamoreau</u> ADDRESS <u>4510 Liberty Heights Ave Baltimore 7</u>  |                           | 24a. REC'D BY REGISTRAR <u>Pessie Thompson</u>   |                                  |
| 24b. REGISTRAR'S SIGNATURE  |                           | DATE <u>9 APR 1956</u>   |                                  |

2074272364

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

APR 9 1956

RECEIVED

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

4256

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>c. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  |   |  | c. LENGTH OF STAY IN lb<br><b>3 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Bethesda, Md.</b>   |  |   |  | d. STREET ADDRESS<br><b>RR-2 Box-9</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First <b>Randolph</b> Middle <b>WYATT</b> Last <b>MC LAINE</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>13</b> Year <b>1956</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-19-54</b>  |  |
| 9. AGE (In years lost birthday) yrs. <b>1</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington State</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>Calvin MC LAINE</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Clara GOFF</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>(Father) Calvin MC LAINE RR-2 Box-9 Waldorf, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b><br><b>754.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac Arrest</b><br>DUE TO (c) <b>Congenital Heart Disease</b>  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>24 hrs</b><br><b>19 mos</b>               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>10 April</b> , 19 <b>56</b> , to <b>13 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>13 April</b> , 19 <b>56</b> , and that death occurred at <b>10:50A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-13-56</b><br>ACTUAL SIGNATURE <b>J. H. Peabody Jr.</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>J.W. PEABODY, Jr. LT, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b> |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>4-16-56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.A. PUMPHREY</b><br><b>17557 Wisc. Ave., Bethesda, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>4-13-56</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Barry E. Russell</b>   |  |

VS A15 (4)  
15M 9/35

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

APR 16 1956

RECEIVED

|                                  |  |                          |  |                        |  |                        |  |
|----------------------------------|--|--------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED                 |  | SEX                      |  | AGE                    |  | DATE OF BIRTH          |  |
| JAMES H. HARRIS                  |  | Male                     |  | 45                     |  | 11-15-11               |  |
| RESIDENCE                        |  | OCCUPATION               |  | CAUSE OF DEATH         |  | MANNER OF DEATH        |  |
| 1111 N. W. 10th St., Miami, Fla. |  | Salesman                 |  | Myocardial Infarction  |  | Natural                |  |
| DATE OF DEATH                    |  | PLACE OF DEATH           |  | TIME OF DEATH          |  | SIGNATURE OF PHYSICIAN |  |
| April 15, 1956                   |  | Miami, Fla.              |  | 10:15 AM               |  | J. H. Smith, M.D.      |  |
| SIGNATURE OF DECEASED            |  | SIGNATURE OF NEXT OF KIN |  | SIGNATURE OF WITNESSES |  | SIGNATURE OF REGISTRAR |  |
| [Signature]                      |  | [Signature]              |  | [Signature]            |  | [Signature]            |  |

4165

## CERTIFICATE OF DEATH

04240

Reg. Dist. No.

223

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7 Hickory Ave</u>   |  |  |  | d. STREET ADDRESS <u>7 Hickory Ave.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ralph</u> Middle <u>Campbell</u> Last <u>Miller</u>   |  |  |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>5</u> Year <u>1956</u>  |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Nov. 19, 1891</u>   |  |
| 9. AGE (In years last birthday) <u>64</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>17</u>  |  | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Contractor</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Galesburg, Ill.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>John D. Miller</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Jemima Campbell</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>578-01-7992</u>   |  | 17. INFORMANT <u>Lois Miller</u> Address <u>7 Hickory Ave, Takoma Park, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Carcinoid</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>origin in Cecum</u><br>DUE TO (c) <u>Enteritis</u> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>Mar. 1955</u><br><u>4 yrs.</u>                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)                         |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u><br>p. m. <u></u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>2/24</u> , 19 <u>53</u> , to <u>3/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>56</u> , and that death occurred at <u>10:04</u> A.M. from the causes and on the date stated above.  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Howard T Morse</u>  |  | ADDRESS (Street, city or town, state) <u>7030 Carroll Ave Takoma Park, Md.</u>                                       |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>   |  | DATE SIGNED <u>4/5/56</u>  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>APR. 7, 1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH'N. CEM. RIGGS RD. HYATTSVILLE, MD.</u>  |  | 22d. LOCATION (City, town, or county) (State)   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Stalling</u>   |  | ADDRESS <u>254 CARROLL ST. NW WASH. D.C.</u>   |  | 24a. REC'D BY REGISTRAR <u>J. M. Dodd</u>   |  | 24b. REGISTRAR'S SIGNATURE  |  |
| DATE <u>4/6/56</u>  |  |  |  |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should be notified by the funeral director. Page 1 should be executed the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

4257 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04241

Reg. Dist. No. 216

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montg</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4622 Bayard Blvd</u>  |  |   |  | d. STREET ADDRESS <u>4622 Bayard Blvd</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Valerie Agnes Miller</u>   |  |   |  | DATE OF DEATH <u>Sept 30 1956</u>   |  |   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>July 14 1892</u>                                  |  |
| 9. AGE (If years last birthday) <u>63</u> yrs.  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. relvnt Wash. Star</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>NY</u>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country) <u>NY</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |   |  |
| 13. FATHER'S NAME <u>Henry V. Miller</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Ida Kerber</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, give war or dates of service</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>John V. Miller (brother) same as item 2</u>  |  |   |  |
| 17. INFORMANT <u>John V. Miller (brother)</u>   |  |   |  | Address <u>same as item 2</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>12 hrs</u><br>DUE TO (c) <u></u>   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschait</u>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>MAY 2, 1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>   |  |   |  | ADDRESS <u>2224 Wis Ave</u>   |  | 24a. REC'D BY REGISTRAR <u>5-1-56</u>                                 |  |
|   |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>                  |  |

STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-2-3

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF EXAMINER  
DATE OF EXAMINATION

BUREAU V. S.

MAY 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04242

4258

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>District of Columbia</b> <b>COUNTY</b> <b>47X-3</b>      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2mo.23 days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Bethesda, Md.</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>Jane</b> Last <b>MONROE</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>25</b> Year <b>1956</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>      | 8. DATE OF BIRTH<br><b>8 June 1901</b> |
| 9. AGE (In years last birthday)<br><b>54 yrs.</b>  |                                  | IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Gov't Employee</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>District of Columbia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>John Lewis</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Gardner</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  |
| 17. INFORMANT<br><b>(Friend) Mr. E.Eugene LUTHER</b>   |                                  | Address <b>Arlington, Va. 1424 N. Uhle St.,</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon with widespread Metastases</b><br><b>153X</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO (c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>      |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>2 Feb.</b> , 19 <b>56</b> , to <b>25 Apr.</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>25 April</b> , 19 <b>56</b> , and that death occurred at <b>1:30 P.</b> M, from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE <b>Frederick W. Meyer, Jr.</b>  |                                  | ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-26-56</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Frederick W. Meyer, Jr.</b>   |                                  | <b>U.S. Naval Hospital, Bethesda, Md.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4-28-56</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>S.H. Hines</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE 4-25-56</b>  |  |
| ADDRESS<br><b>2901 14th St. N.W. Wash. D.C.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Gassally</b>   |  |

BUREAU V. S.

APR 27 1956

RECEIVED

## 4259 CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <i>Montgomery</i>  | MARYLAND   | STATE <i>Maryland</i>  | COUNTY <i>Montgomery</i>   |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Bethesda</i>  | LENGTH OF STAY (in this place) <i>13 Mo.</i>   | CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chevy Chase</i> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Resnor Sanatorium</i>  |  | STREET ADDRESS (If rural give location) <i>142. Mapton St.</i>                                   |  |
| 3. NAME OF DECEASED:  |  | 4. DATE (Month) (Day) (Year) OF DEATH:   |  |
| (First) <i>Grace</i>  | (Middle) <i>A.</i>   | (Last) <i>Mullikin</i>   | <i>April 28 1956</i>   |
| 5. SEX: <i>Female</i>   | 6. COLOR OR RACE: <i>White</i>   | 7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <i>Widow</i>                                   | 8. DATE OF BIRTH: <i>March 20, 1865</i>  |
| 9. AGE last birthday <i>91</i> yrs.   |  | IF UNDER 1 YEAR: Months <i>1</i> Days <i>8</i>   | IF UNDER 24 HRS. Hours <i></i> Min. <i></i>                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>   | 11. BIRTHPLACE (State or foreign country): <i>March 28, 1865</i>                 |
| 12. CITIZEN OF WHAT COUNTRY: <i>USA</i>   |  | 13. FATHER'S NAME: <i>George McNeal</i>  |  |
| 14. MOTHER'S MAIDEN NAME: <i>Susan J. McNeal</i>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>                        |  |
| 16. SOCIAL SECURITY NO. <i>None</i>   |  | 17. INFORMANT'S ADDRESS: <i>Deceased</i>   |  |
| 18. MEDICAL CERTIFICATION   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |
| IMMEDIATE CAUSE (A) <i>Coronary Arteriosclerosis &amp; Pericarditis</i>   |  |  |  |
| ANTECEDENT CAUSE (B) <i>Arteriosclerotic Heart Disease</i>  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |
| 19A. DATE OF OPERATION:   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                                     |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>August, 1955</i> , to <i>April, 1956</i> , that I last saw the deceased alive on <i>April 28, 1956</i> , and that death occurred at <i>6:55 P.</i> M, from the causes and on the date stated above. |  |  |  |
| SIGNATURE <i>Donald C. Ekman</i>  |  | DATE SIGNED <i>April 28, 1956</i>  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | DATE THEREOF <i>5-1-56</i>   |  |
| NAME OF CEMETERY OR CREMATORY <i>Woodlawn Memorial</i>  |  | LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>                               |  |
| DATE REC'D BY LOCAL REGISTRAR <i>4/30/56</i>  |  | REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>  |  |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>  |  | ADDRESS <i>Bethesda, Md.</i>   |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S. )

MAY 2 1956

RECEIVED

4260

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |   |
| c. LENGTH OF STAY IN 1b<br><b>37 YRS.</b>   |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1905 ARCOLA AVENUE</b>   |   | d. STREET ADDRESS<br><b>1905 ARCOLA AVENUE</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEOFFREY</b> Middle <b>MacDONALD</b> Last <b>NAIRN</b>  |   | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>19</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/25/97</b>  |
| 9. AGE (In years last birthday)<br><b>58</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>POULTRYMAN</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON, D.C.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>WILLIAM WALLACE NAIRN</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>FRANCES NOERR</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b> (If yes, give war or dates of service)<br><b>WWI</b>   |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   |
| 17. INFORMANT<br><b>MRS. MAE C. NAIRN, 1905 Arcola Ave.</b>   |   | Address<br><b>Silver Spring, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary + thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b> |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>11/5/49</b> , 19____, to <b>4/19/56</b> , 19____, that I last saw the deceased alive on <b>4/18/56</b> , 19____, and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.  |   |   |   |
| ACTUAL SIGNATURE<br><b>Patrick C Jameson</b>  |   | DATE SIGNED<br><b>12020 Ga Silver Spring 4/19/56</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>PATRICK C. JAMESON</b>  |   | <b>12020 Ga. Ave., Silver Spring, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>   | 22b. DATE THEREOF<br><b>4/21/56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN CREMATORY</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>PRINCE GEO. COUNTY, MD.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Walter E. Humphrey</b>   |   | 24a. REC'D BY REGISTRAR<br><b>4/24/56</b>   |   |
| ADDRESS<br><b>SILVER SPRING, MD.</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Frances Potter</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 26 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04245

Reg. Dist. No. 223

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>D.O.A.</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>New York</u> b. COUNTY <u>Queens</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forrest Hills Long Island</u><br>d. STREET ADDRESS <u>9308 Queens Blvd.</u> |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Paul</u> Middle <u>Sam</u> Last <u>Nechamkus</u>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>4</u> - Day <u>2</u> - Year <u>1956</u>   |  |   |  |
| <b>5. SEX</b><br><u>Male</u>   |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>10-5-1904</u>                             |  |
| <b>9. AGE</b> (In years last birthday) <u>51</u> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>                                  |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Musician</u>  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Musician</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>New York</u>     |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>Amer.</u>  |  |  |  | <b>13. FATHER'S NAME</b><br><u>Sam Nechamkus</u>  |  |   |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Rose Nechamkus</u>   |  |  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)<br><u>No</u>   |  |   |  |
| <b>16. SOCIAL SECURITY NO.</b><br><u>  </u>  |  |  |  | <b>17. INFORMANT</b><br><u>Mrs. Helen Nechamkus - 4308 Queens Blvd. Forrest Hills N.Y.</u>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b><br/>           IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br/>           DUE TO <u>420.1</u><br/>           Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u><br/>           DUE TO (c) <u>  </u> </div> <div style="width: 15%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b><br/> <u>1/2 hr</u> </div> </div> |  |  |  |   |  |   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><u>  </u>  |  |  |  |   |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>  |  |   |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |  |  |  | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |  |   |  |
| <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>  </u> |  | <b>20f. (City or town)</b><br><u>  </u>   |  | <b>(County)</b><br><u>  </u>  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>, Inspection</b> <input checked="" type="checkbox"/> <b>, Inquiry</b> <input checked="" type="checkbox"/> <b>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>  |  |  |  |   |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>FRANK J. BOSCHART</u> <b>M.D.</b>   |  |  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>  |  |   |  |
| <b>EXAMINER'S NAME (Type)</b> <u>Frank J. Boschart</u>   |  |  |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>  |  |   |  |
| <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |  |  |  | <b>DATE SIGNED</b><br><u>4-2-56</u>   |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  | <b>22b. DATE TIME OF</b><br><u>April 5, 1956</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>King David Mem Garden</u>   |  | <b>22d. LOCATION (City, town, or county)</b><br><u>Falls Church Va.</u> |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>B. Naugausky &amp; Son 3501-14th St NW</u>   |  |  |  | <b>24a. REC'D BY REGISTRAR</b><br><u>4/8/56</u>   |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>J. J. ...</u>                   |  |

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |                               |  |
|---|--|-------------------------------|--|
| <p>NAME OF DECEASED: _____</p>              |  | <p>DATE OF DEATH: _____</p>   |  |
| <p>AGE: _____</p>                           |  | <p>SEX: _____</p>             |  |
| <p>RESIDENCE: _____</p>                     |  | <p>OCCUPATION: _____</p>      |  |
| <p>CAUSE OF DEATH: _____</p>                |  | <p>MANNER OF DEATH: _____</p> |  |
| <p>DATE OF BURIAL: _____</p>                |  | <p>PLACE OF BURIAL: _____</p> |  |
| <p>SIGNATURE OF MEDICAL EXAMINER: _____</p> |  | <p>DATE: _____</p>            |  |

BUREAU V. S.

APR 9 1956

RECEIVED



1

4261

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04246

Reg. Dist. No. 276

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Dist. of Col.</u> b. COUNTY <u>Washington</u>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>  |                                  | d. STREET ADDRESS <u>3708 Oliver St.</u>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Mary O'Boyle</u>  |                                  | 4. DATE OF DEATH Month Day Year <u>April 23 1956</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 23, 1881</u>                            |
| 9. AGE (In years last birthday) <u>75</u> yrs.   |                                  | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Scranton, Pennsylvania</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Cornelius McDermott</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Mary Ellen Gilleran</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>   |                                  | 16. SOCIAL SECURITY NO. <u>-</u>   |  |
| 17. INFORMANT <u>Daughter, Mrs. Clare Grimm - above</u>  |                                  | Address <u>-</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u><br>DUE TO (b) <u>HYPERTENSION</u><br>DUE TO (c) <u>-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 DAY</u><br><u>20 YR</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>56</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <u>Leo I. Donovan M.D.</u>  |                                  | DATE SIGNED <u>4/23/56</u>   |  |
| PHYSICIAN'S NAME (Type) <u>LEO I. DONOVAN M.D.</u>   |                                  | ADDRESS (Street, city or town, state)  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 22b. DATE THEREOF <u>4-26-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>  | 22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Naulon</u>   |                                  | ADDRESS <u>3851-GA. Ave. N.W.</u>  |  |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>   |                                  | DATE <u>4-23-56</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1956

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY                      |  | 2. SEX<br>Male                          |  | 3. AGE<br>35                                      |  | 4. DATE OF BIRTH<br>12-1-20                     |  | 5. PLACE OF BIRTH<br>Memphis, Tenn.             |  |
| 6. OCCUPATION<br>Singer                                    |  | 7. MARITAL STATUS<br>Single             |  | 8. COLOR<br>White                                 |  | 9. HIGHEST SCHOOLING<br>High School             |  | 10. RELIGION<br>Methodist                       |  |
| 11. DECEASED'S ADDRESS<br>2121 E. 12th St., Baltimore, Md. |  | 12. DECEASED'S PHONE<br>7-1234          |  | 13. DECEASED'S SOCIAL SECURITY NO.<br>1-23-456789 |  | 14. DECEASED'S MARRIAGE NO.<br>1                |  | 15. DECEASED'S SERVICE NO.<br>None              |  |
| 16. DECEASED'S RACE<br>White                               |  | 17. DECEASED'S SEX<br>Male              |  | 18. DECEASED'S AGE<br>35                          |  | 19. DECEASED'S DATE OF BIRTH<br>12-1-20         |  | 20. DECEASED'S PLACE OF BIRTH<br>Memphis, Tenn. |  |
| 21. DECEASED'S OCCUPATION<br>Singer                        |  | 22. DECEASED'S MARITAL STATUS<br>Single |  | 23. DECEASED'S COLOR<br>White                     |  | 24. DECEASED'S HIGHEST SCHOOLING<br>High School |  | 25. DECEASED'S RELIGION<br>Methodist            |  |
| 26. DECEASED'S ADDRESS<br>2121 E. 12th St., Baltimore, Md. |  | 27. DECEASED'S PHONE<br>7-1234          |  | 28. DECEASED'S SOCIAL SECURITY NO.<br>1-23-456789 |  | 29. DECEASED'S MARRIAGE NO.<br>1                |  | 30. DECEASED'S SERVICE NO.<br>None              |  |
| 31. DECEASED'S RACE<br>White                               |  | 32. DECEASED'S SEX<br>Male              |  | 33. DECEASED'S AGE<br>35                          |  | 34. DECEASED'S DATE OF BIRTH<br>12-1-20         |  | 35. DECEASED'S PLACE OF BIRTH<br>Memphis, Tenn. |  |
| 36. DECEASED'S OCCUPATION<br>Singer                        |  | 37. DECEASED'S MARITAL STATUS<br>Single |  | 38. DECEASED'S COLOR<br>White                     |  | 39. DECEASED'S HIGHEST SCHOOLING<br>High School |  | 40. DECEASED'S RELIGION<br>Methodist            |  |
| 41. DECEASED'S ADDRESS<br>2121 E. 12th St., Baltimore, Md. |  | 42. DECEASED'S PHONE<br>7-1234          |  | 43. DECEASED'S SOCIAL SECURITY NO.<br>1-23-456789 |  | 44. DECEASED'S MARRIAGE NO.<br>1                |  | 45. DECEASED'S SERVICE NO.<br>None              |  |
| 46. DECEASED'S RACE<br>White                               |  | 47. DECEASED'S SEX<br>Male              |  | 48. DECEASED'S AGE<br>35                          |  | 49. DECEASED'S DATE OF BIRTH<br>12-1-20         |  | 50. DECEASED'S PLACE OF BIRTH<br>Memphis, Tenn. |  |
| 51. DECEASED'S OCCUPATION<br>Singer                        |  | 52. DECEASED'S MARITAL STATUS<br>Single |  | 53. DECEASED'S COLOR<br>White                     |  | 54. DECEASED'S HIGHEST SCHOOLING<br>High School |  | 55. DECEASED'S RELIGION<br>Methodist            |  |
| 56. DECEASED'S ADDRESS<br>2121 E. 12th St., Baltimore, Md. |  | 57. DECEASED'S PHONE<br>7-1234          |  | 58. DECEASED'S SOCIAL SECURITY NO.<br>1-23-456789 |  | 59. DECEASED'S MARRIAGE NO.<br>1                |  | 60. DECEASED'S SERVICE NO.<br>None              |  |
| 61. DECEASED'S RACE<br>White                               |  | 62. DECEASED'S SEX<br>Male              |  | 63. DECEASED'S AGE<br>35                          |  | 64. DECEASED'S DATE OF BIRTH<br>12-1-20         |  | 65. DECEASED'S PLACE OF BIRTH<br>Memphis, Tenn. |  |
| 66. DECEASED'S OCCUPATION<br>Singer                        |  | 67. DECEASED'S MARITAL STATUS<br>Single |  | 68. DECEASED'S COLOR<br>White                     |  | 69. DECEASED'S HIGHEST SCHOOLING<br>High School |  | 70. DECEASED'S RELIGION<br>Methodist            |  |
| 71. DECEASED'S ADDRESS<br>2121 E. 12th St., Baltimore, Md. |  | 72. DECEASED'S PHONE<br>7-1234          |  | 73. DECEASED'S SOCIAL SECURITY NO.<br>1-23-456789 |  | 74. DECEASED'S MARRIAGE NO.<br>1                |  | 75. DECEASED'S SERVICE NO.<br>None              |  |
| 76. DECEASED'S RACE<br>White                               |  | 77. DECEASED'S SEX<br>Male              |  | 78. DECEASED'S AGE<br>35                          |  | 79. DECEASED'S DATE OF BIRTH<br>12-1-20         |  | 80. DECEASED'S PLACE OF BIRTH<br>Memphis, Tenn. |  |
| 81. DECEASED'S OCCUPATION<br>Singer                        |  | 82. DECEASED'S MARITAL STATUS<br>Single |  | 83. DECEASED'S COLOR<br>White                     |  | 84. DECEASED'S HIGHEST SCHOOLING<br>High School |  | 85. DECEASED'S RELIGION<br>Methodist            |  |
| 86. DECEASED'S ADDRESS<br>2121 E. 12th St., Baltimore, Md. |  | 87. DECEASED'S PHONE<br>7-1234          |  | 88. DECEASED'S SOCIAL SECURITY NO.<br>1-23-456789 |  | 89. DECEASED'S MARRIAGE NO.<br>1                |  | 90. DECEASED'S SERVICE NO.<br>None              |  |
| 91. DECEASED'S RACE<br>White                               |  | 92. DECEASED'S SEX<br>Male              |  | 93. DECEASED'S AGE<br>35                          |  | 94. DECEASED'S DATE OF BIRTH<br>12-1-20         |  | 95. DECEASED'S PLACE OF BIRTH<br>Memphis, Tenn. |  |
| 96. DECEASED'S OCCUPATION<br>Singer                        |  | 97. DECEASED'S MARITAL STATUS<br>Single |  | 98. DECEASED'S COLOR<br>White                     |  | 99. DECEASED'S HIGHEST SCHOOLING<br>High School |  | 100. DECEASED'S RELIGION<br>Methodist           |  |

BUREAU V. 1

APR 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4262

## CERTIFICATE OF DEATH

Reg. Dist. No. 042474

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>MONTGOMERY</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>56 WHEATON, SILVER SPRING</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8 days</b>  |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WHEATON, SILVER SPRING</b>  |  |   |  | 56  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>11,718 LYTLE STREET</b>   |  |   |  | d. STREET ADDRESS<br><b>3007 DAWSON AVENUE</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>NELLIE</b> Middle <b>WILLIAMS</b> Last <b>O'BRIEN</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>18</b> Year <b>1956</b>   |  |   |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JULY 7, 1891</b>   |  |
| 9. AGE (In years last birthday)<br><b>64 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 13. FATHER'S NAME<br><b>WADE HAMPTON WILLIAMS</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>EMMA DALTON</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>MR. WILLIAM W. O'BRIEN, 3107 DAWSON AVE.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diabetic Glomerulonephrosis</b><br>DUE TO <b>260x</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Diabetes Mellitus</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerosis -</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos.</b><br><b>2 yrs.</b>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |  | 20d. INJURY OCCURRED<br>While Not while at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>1-30, 1953</b> , to <b>4-18, 1956</b> , that I last saw the deceased alive on <b>4-17, 1956</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Francis X. Richardson</b> M.D.   |  |   |  | ADDRESS (Street, city or town, state)<br><b>7717-Altshuler N.W.</b>   |  | DATE SIGNED<br><b>4-19-56</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>FRANCIS X. RICHARDSON</b>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>4/21/56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JOHN'S CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>MONTGOMERY COUNTY, MARYLAND</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner &amp; Humphrey</b>   |  |   |  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>424/56</b>  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Francis Vatter</b>   |  |   |  |

**BUREAU T. J.**

APR 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4263

04248

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |                               |  |                                 |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>   |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Suburban Hospital</u>  |                               | d. STREET ADDRESS <u>104 George St.</u>  |                                 |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William Cramer O'Brien</u>   |                               | 4. DATE OF DEATH Month Day Year <u>4 - 20 1956</u>   |                                 |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-25-84</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs.  |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |                                 |
| 13. FATHER'S NAME <u>Michael Obrien</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Matilda Cramer</u>   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>Matilda Chamberlin - daughter</u>   |                                 |
| 17. INFORMANT Address <u>Matilda Chamberlin - daughter</u>  |                               |  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u><br>DUE TO <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis</u><br>(c) <u>Myocardial infarction</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of colon</u> |                               |  |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I attended the deceased from <u>April 9, 1954</u> , to <u>April 20, 1954</u> , that I last saw the deceased alive on <u>April 20, 1954</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.  |                               |  |                                 |
| ACTUAL SIGNATURE <u>George Sharpe</u> M.D.  |                               | ADDRESS (Street, city or town, state) <u>10644 Connecticut Ave</u>   |                                 |
| PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u>   |                               | DATE SIGNED <u>4-20-56</u>   |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>4-24-56</u>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Baller Pa -</u>   |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett L. Garton</u> ADDRESS <u>Gaithersburg Md</u>   |                               | 24a. REC'D BY REGISTRAR <u>4-24-56</u>   |                                 |
|   |                               | 24b. REGISTRAR'S SIGNATURE <u>Bessie W. Thompson</u>   |                                 |



BUREAU V. 3.

APR 26 1956

RECEIVED

4264

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>   |  |   |  |
| c. LENGTH OF STAY IN 1b <u>48 years</u>  |  |   |  |  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3760 Howard Avenue</u>   |  |   |  | d. STREET ADDRESS <u>3760 Howard Avenue</u>  |  |   |  |
|  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>Christine</u> Last <u>Palmer</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>13</u> Year <u>1956</u>  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>white</u>                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>July 31, 1882</u>                                   |  |
|  |  |   |  | 9. AGE (In years last birthday) <u>73</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>                       |  |
| 13. FATHER'S NAME <u>John A. Wagner</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Scherrer</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>None</u>               |  | 17. INFORMANT <u>Mrs. Lillian Burton</u> Address <u>3760 Howard Avenue Kensington, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma right kidney with metastases</u><br>180X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
|  |  |   |  | 20f. (City or town)  |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Dec. 1, 1934</u> , to <u>April 13, 1956</u> , that I last saw the deceased alive on <u>April 11, 1956</u> , and that death occurred at <u>2:43 AM</u> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>3924 Baltimore Street</u> DATE SIGNED <u>April 13, 1956</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u>  |  |   |  | <u>Kensington, Maryland</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>4/16/1956</u>                |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</u>   |  |   |  | 24a. REC'D BY REGISTRAR <u>DATE 4-16-56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>                    |  |
|  |  |   |  |  |  | Maryland  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                 |  |          |  |
|-----------------|--|----------|--|
| PLACE OF DEATH  |  | DECEASED |  |
| RESIDENCE       |  | DECEASED |  |
| DATE OF DEATH   |  | DECEASED |  |
| TIME OF DEATH   |  | DECEASED |  |
| CAUSE OF DEATH  |  | DECEASED |  |
| MANNER OF DEATH |  | DECEASED |  |
| AGE             |  | DECEASED |  |
| SEX             |  | DECEASED |  |
| RACE            |  | DECEASED |  |
| RELIGION        |  | DECEASED |  |
| EDUCATION       |  | DECEASED |  |
| OCCUPATION      |  | DECEASED |  |
| MARRIAGE        |  | DECEASED |  |
| CHILDREN        |  | DECEASED |  |
| SIBLINGS        |  | DECEASED |  |
| PARENTS         |  | DECEASED |  |
| GRANDPARENTS    |  | DECEASED |  |
| OTHER RELATIVES |  | DECEASED |  |
| FRIENDS         |  | DECEASED |  |
| NEIGHBORS       |  | DECEASED |  |
| OTHER           |  | DECEASED |  |

BUREAU V. S.

APR 18 1956

RECEIVED

APR 18 1956  
BALTIMORE, MARYLAND  
STATE DEPARTMENT OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4265

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04250

Reg. Dist. No. 218

|  |  |   |  |  |  |                                 |  |
|--|--|---|--|--|--|---------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>D. C.</u> <u>none</u>           |  |                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>   |  |                                 |  |
| c. LENGTH OF STAY IN 1b <u>3 mo</u>  |  |   |  | d. STREET ADDRESS <u>1762 Columbia Rd</u>  |  |                                 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R70 &amp; 1</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                 |  |
| 3. NAME OF DECEASED (Type or print) <u>Theresa Marcelle Paxton</u>   |  |   |  | 4. DATE OF DEATH Month <u>Apr</u> Day <u>28</u> Year <u>1956</u>   |  |                                 |  |
| 5. SEX <u>female</u>   |  | 6. COLOR OR RACE <u>white</u>                 |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>1-21-56</u> |  |
| 9. AGE (In years last birthday) <u>3</u> yrs.  |  | IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u> |  | IF UNDER 24 HRS. Hours <u></u> Min. <u></u>  |  |                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>  |  |                                 |  |
| 11. BIRTHPLACE (State or foreign country) <u>usa</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>usa</u>  |  |                                 |  |
| 13. FATHER'S NAME <u>unknown</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Barbara Paxton</u>   |  |                                 |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  |   |  | 16. SOCIAL SECURITY NO.  |  |                                 |  |
| 17. INFORMANT <u>Social Service League - records</u>   |  |   |  | Address  |  |                                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>475X</u> <u>Cyphria</u><br>DUE TO (b) <u>upper Respiratory Infection</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> |  |   |  |  |  |                                 |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>  |  |   |  |  |  |                                 |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |                                 |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                 |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |                                 |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)   |  |                                 |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .                                  |  |   |  |  |  |                                 |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |                                 |  |
| EXAMINER'S NAME (Type) <u>Frank J. Broschert</u>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |                                 |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |                                 |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |   |  | 22b. DATE THEREOF <u>April 30, 1956</u>  |  |                                 |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St Lukes</u>   |  |   |  | 22d. LOCATION (City, town, or county) (State) <u>Redland Maryland</u>  |  |                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raynor Barber</u>  |  |   |  | ADDRESS <u>Laytonville md</u>  |  |                                 |  |
| 24a. REC'D BY REGISTRAR <u>5-1-56</u>  |  |   |  | 24b. REGISTRAR'S SIGNATURE <u>Abundant G. Cooke</u>  |  |                                 |  |

2

2051221395

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAY 7 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4266

## CERTIFICATE OF DEATH

04251

Reg. Dist. No. 216

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> b. COUNTY <b>Montgomery</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda, Maryland</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington (16)</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  | d. STREET ADDRESS<br><b>5116 Scarsdale Road, Sumner</b>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Graham</b> Last <b>Pearce</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>24</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 14, 1885</b> |
| 9. AGE (In years last birthday) yrs. <b>71</b>  |                                  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>10</b>   |   |
| IF UNDER 24 HRS.<br>Hours <b>10</b> Min. <b>10</b>  |                                  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Richard Graham</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma McKinnon</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>The Medical Record</b>  |                                  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b><br>204.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute myelocytic leukemia</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pneumonia - left lower lobe. Generalized arteriosclerosis</b><br>2. INTERVAL BETWEEN ONSET AND DEATH |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>March 12, 1956</b> , to <b>April 24, 1956</b> , that I last saw the deceased alive on <b>April 24, 1956</b> , and that death occurred at <b>9:00 A.</b> from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE <b>Martin Schick</b>   |                                  | DATE SIGNED <b>4/24/56</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Martin Schick, M. D.</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center<br/>The National Institutes of Health<br/>Bethesda 14, Maryland</b>                         |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-Transit 4-26-56</b>  |                                  | 22b. DATE THEREOF   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bellefontaine</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Logan Co. Ohio</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>4-25-56</b>   |   |
| ADDRESS<br><b>Bethesda, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Bennett Thompson</b>   |   |

BUREAU V. S.

APR 30 1956

RECEIVED

4267

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                  |   |                                      |   |   |   |  |
|---|----------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>P.6.</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                  |   |                                      | c. LENGTH OF STAY IN 1b<br><b>one day</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>   |                                  |   |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>PENNELL</b>  |                                  |   |                                      | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>10</b> Year <b>19 56</b>  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-13-1898</b> | 9. AGE (In years last birthday) yrs.<br><b>58</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Massachusetts</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                   |  |
| 13. FATHER'S NAME<br><b>Swan Elison</b>   |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>Unknown</b>  |                                      | 17. (Name and address)<br><b>Hyattsville, Maryland</b><br><b>Marjorie KEESEY, 3415 Rutgers Street,</b>                                    |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage, Cerebral</b><br>DUE TO (b) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>Indef.</b>          |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>9 April</b> , 19 <b>56</b> , to <b>10 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10 April 1956</b> , and that death occurred at <b>12:30P</b> M, from the causes and on the date stated above.  |                                  |   |                                      |   |   |   |  |
| ACTUAL SIGNATURE <b>R. J. Mc Carthy</b>   |                                  |   |                                      | ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-11-56</b>                                |   |   |  |
| PHYSICIAN'S NAME (Type) <b>R. J. Mc Carthy, CDR, MC, USN</b>  |                                  |   |                                      | U.S. Naval Hospital, Bethesda, Md.  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4-13-56</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.A. Pumphrey</b><br><b>7567 Wisc. Ave., Bethesda, Md.</b>   |                                  |   |                                      | 24a. REC'D BY REGISTRAR<br><b>DATE 4-11-56</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Passelly</b>                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04253

Reg. Dist. No. 214

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>  |  |  |  | c. LENGTH OF STAY IN 1b  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospital, give street address) <u>Kensington Gardens Nursing</u>   |  |  |  | d. STREET ADDRESS <u>3000 McComas Ave</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>LAURA</u> First <u>VIRGINIA</u> Middle <u>PERFECT</u> Last   |  |  |  | 4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1956</u>   |  |   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Aug 15 1883</u>                               |  |
| 9. AGE (10 years last birthday) <u>72</u> yrs.  |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>md</u>               |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <u>Louis D Welbourne</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Laura V. Miller</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address <u>Lillian Brucher 3000 McComas Ave</u>     |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>931X</u> <u>Central Penn Hosp (Arterio in 1951)</u><br>DUE TO <u>Arterio Sclerosis Benign</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Arterio Sclerosis Benign</u><br>DUE TO (c) <u>Arterio Sclerosis Benign</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u><br><u>yr 5.</u> |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                              |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D.  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type)  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |  |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF <u>4-21-56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Real Funeral Home 4812 Galt Ave NW Wash DC</u>  |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>4/24/56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>                  |  |



11208  
4368  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                   |  |                          |  |                           |  |
|-----------------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED               |  | 2. SEX                   |  | 3. AGE                    |  |
| 4. OCCUPATION                     |  | 5. MARITAL STATUS        |  | 6. PLACE OF BIRTH         |  |
| 7. DATE OF DEATH                  |  | 8. TIME OF DEATH         |  | 9. PLACE OF DEATH         |  |
| 10. CAUSE OF DEATH                |  | 11. MANNER OF DEATH      |  | 12. SIGNATURE OF EXAMINER |  |
| 13. SIGNATURE OF WITNESS          |  | 14. SIGNATURE OF CORONER |  | 15. SIGNATURE OF JURY     |  |
| 16. SIGNATURE OF MEDICAL EXAMINER |  | 17. SIGNATURE OF JURY    |  | 18. SIGNATURE OF JURY     |  |
| 19. SIGNATURE OF JURY             |  | 20. SIGNATURE OF JURY    |  | 21. SIGNATURE OF JURY     |  |
| 22. SIGNATURE OF JURY             |  | 23. SIGNATURE OF JURY    |  | 24. SIGNATURE OF JURY     |  |
| 25. SIGNATURE OF JURY             |  | 26. SIGNATURE OF JURY    |  | 27. SIGNATURE OF JURY     |  |
| 28. SIGNATURE OF JURY             |  | 29. SIGNATURE OF JURY    |  | 30. SIGNATURE OF JURY     |  |
| 31. SIGNATURE OF JURY             |  | 32. SIGNATURE OF JURY    |  | 33. SIGNATURE OF JURY     |  |
| 34. SIGNATURE OF JURY             |  | 35. SIGNATURE OF JURY    |  | 36. SIGNATURE OF JURY     |  |
| 37. SIGNATURE OF JURY             |  | 38. SIGNATURE OF JURY    |  | 39. SIGNATURE OF JURY     |  |
| 40. SIGNATURE OF JURY             |  | 41. SIGNATURE OF JURY    |  | 42. SIGNATURE OF JURY     |  |
| 43. SIGNATURE OF JURY             |  | 44. SIGNATURE OF JURY    |  | 45. SIGNATURE OF JURY     |  |
| 46. SIGNATURE OF JURY             |  | 47. SIGNATURE OF JURY    |  | 48. SIGNATURE OF JURY     |  |
| 49. SIGNATURE OF JURY             |  | 50. SIGNATURE OF JURY    |  | 51. SIGNATURE OF JURY     |  |
| 52. SIGNATURE OF JURY             |  | 53. SIGNATURE OF JURY    |  | 54. SIGNATURE OF JURY     |  |
| 55. SIGNATURE OF JURY             |  | 56. SIGNATURE OF JURY    |  | 57. SIGNATURE OF JURY     |  |
| 58. SIGNATURE OF JURY             |  | 59. SIGNATURE OF JURY    |  | 60. SIGNATURE OF JURY     |  |
| 61. SIGNATURE OF JURY             |  | 62. SIGNATURE OF JURY    |  | 63. SIGNATURE OF JURY     |  |
| 64. SIGNATURE OF JURY             |  | 65. SIGNATURE OF JURY    |  | 66. SIGNATURE OF JURY     |  |
| 67. SIGNATURE OF JURY             |  | 68. SIGNATURE OF JURY    |  | 69. SIGNATURE OF JURY     |  |
| 70. SIGNATURE OF JURY             |  | 71. SIGNATURE OF JURY    |  | 72. SIGNATURE OF JURY     |  |
| 73. SIGNATURE OF JURY             |  | 74. SIGNATURE OF JURY    |  | 75. SIGNATURE OF JURY     |  |
| 76. SIGNATURE OF JURY             |  | 77. SIGNATURE OF JURY    |  | 78. SIGNATURE OF JURY     |  |
| 79. SIGNATURE OF JURY             |  | 80. SIGNATURE OF JURY    |  | 81. SIGNATURE OF JURY     |  |
| 82. SIGNATURE OF JURY             |  | 83. SIGNATURE OF JURY    |  | 84. SIGNATURE OF JURY     |  |
| 85. SIGNATURE OF JURY             |  | 86. SIGNATURE OF JURY    |  | 87. SIGNATURE OF JURY     |  |
| 88. SIGNATURE OF JURY             |  | 89. SIGNATURE OF JURY    |  | 90. SIGNATURE OF JURY     |  |
| 91. SIGNATURE OF JURY             |  | 92. SIGNATURE OF JURY    |  | 93. SIGNATURE OF JURY     |  |
| 94. SIGNATURE OF JURY             |  | 95. SIGNATURE OF JURY    |  | 96. SIGNATURE OF JURY     |  |
| 97. SIGNATURE OF JURY             |  | 98. SIGNATURE OF JURY    |  | 99. SIGNATURE OF JURY     |  |
| 100. SIGNATURE OF JURY            |  | 101. SIGNATURE OF JURY   |  | 102. SIGNATURE OF JURY    |  |

RECEIVED  
APR 26 1956  
BUREAU V. L.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4269

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

04254

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>  |   |  | c. LENGTH OF STAY IN 1b <b>2 days</b>   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>   |   |  | d. STREET ADDRESS <b>307 Maple Drive</b>  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle <b>Marian</b> Last <b>Poole</b>  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>4</b> Year <b>19 56</b>   |  |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>9/3/87</b>  |  | 9. AGE (In years last birthday) <b>68 yrs.</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |   | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>              |  |
| 13. FATHER'S NAME <b>George Frank Crown</b>  |   |  | 14. MOTHER'S MAIDEN NAME <b>Laura Virginia Ricketts</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |   | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |   | 17. INFORMANT Address <b>Hospital Record</b>                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1. Chronic glomerular nephritis</b><br><b>592X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>2. Hypertensive cardiovascular disease</b><br>DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b><br><b>5 years</b> |   |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b><br><b>Diabetes mellitus</b> <b>10 years.</b>   |   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)   | (County)   | (State)  |
| 21. I certify that I attended the deceased from <b>1940</b> , 19____, to <b>April 4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 4</b> , 19 <b>56</b> , and that death occurred at <b>3:40</b> A.M. from the causes and on the date stated above.   |   |  |   |  |  |
| ACTUAL SIGNATURE <b>W. A. Linthicum</b>  |   | M.D. <b>Rockville, Md.</b>   |   | DATE SIGNED <b>4/4/56</b>  |  |
| PHYSICIAN'S NAME (Type) <b>W. A. Linthicum, M. D.</b> <b>Rockville, Md.</b>  |   |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>4-8-56</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Derwood</b>  |   | 22d. LOCATION (City, town, or county) (State) <b>Derwood, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Rockville, Md.</b>  |   | ADDRESS  |   | 24a. REC'D BY REGISTRAR <b>4-6-56</b>                                  | 24b. REGISTRAR'S SIGNATURE <b>Gertrude B Lawley</b>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04255

4270

## CERTIFICATE OF DEATH

Reg. Dist. No.

215

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> b. COUNTY <b>Columbia</b>     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   | c. LENGTH OF STAY IN 1b<br><b>103 days</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>The Clinical Center, Bethesda, Md.</b>  |   | d. STREET ADDRESS<br><b>1207-6<math>\frac{1}{2}</math> St., N. W.</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joyce</b> Middle <b>Elizabeth</b> Last <b>Porter</b>  |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>11</b> , Year <b>1956</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 17, 1939</b>  |
| 9. AGE (In years last birthday)<br><b>17</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>District of Columbia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Sylvester Shorter</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lillian Phillips</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT The Medical Record Address<br><b>The Clinical Center, Bethesda, Maryland</b>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b><br><b>204.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Necrosis of epiglottis, Monilia infection, pharynx, larynx</b><br>DUE TO (c) <b>Acute granulocytic leukemia</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hours</b><br><b>7 months</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>December 30, 1956</b> to <b>April 11, 1956</b> , that I last saw the deceased alive on <b>April 11, 1956</b> , and that death occurred at <b>4:37 A.</b> M., from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br><b>Martin Schick</b>  |   | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br>DATE SIGNED<br><b>4/4/56</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Martin Schick, M. D.</b>  |   | <b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>  |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><b>4-14-56</b>  | 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Bethesda Md. D.C.</b>                         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. S. Washington</b>   |   | ADDRESS<br><b>467 N st NW</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>4-14-56</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Carrie Campbell</b><br><b>May 6. 1956</b>  |   |

CERTIFICATE OF DEATH

|   |  |  |  |                                  |  |                                     |  |
|---|--|--|--|----------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED<br>JAMES H. HARRIS   |  | SEX<br>Male                              |  | AGE<br>45                        |  | DATE OF BIRTH<br>1910               |  |
| PLACE OF BIRTH<br>Baltimore, Md.  |  | OCCUPATION<br>Salesman                   |  | EDUCATION<br>High School         |  | MARRIAGE<br>Married                 |  |
| DATE OF DEATH<br>April 23, 1956   |  | PLACE OF DEATH<br>Home                   |  | CAUSE OF DEATH<br>Heart Disease  |  | MANNER OF DEATH<br>Natural          |  |
| CERTIFICATE OF DEATH<br>This is to certify that the above named person died on the 23rd day of April, 1956, at the place of death stated above. |  | SIGNATURE OF DECEASED<br>James H. Harris |  | SIGNATURE OF WITNESS<br>John Doe |  | SIGNATURE OF PHYSICIAN<br>Dr. Smith |  |
| LOCAL HEALTH OFFICER<br>John Doe  |  | COUNTY CLERK<br>Jane Smith               |  | STATE CLERK<br>John Doe          |  | FEDERAL CLERK<br>Jane Smith         |  |

BUREAU V. S.

APR 23 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4: film GL95 4-9-56L

## CERTIFICATE OF DEATH

04256

Reg. Dist. No. 216

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |  |  |  | c. LENGTH OF STAY IN 1b <b>14 hours</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hosp.</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>   |  |  |  | d. STREET ADDRESS <b>1005 Crawford Drive</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Celeste Elizabeth Reynolds</b>   |  |  |  | 4. DATE OF DEATH <b>March 2</b> Day Year <b>1956</b>   |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>May 28, 1878</b>                                   |  |
| 9. AGE (In years last birthday) <b>77</b> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Stenographer</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Immigration Serv.</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Georgia</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME <b>unknown</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT <b>Niece, Ann E. Mc Hugh - above</b>  |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>420.1 DUE TO <b>Coronary thrombosis left</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b><br>(c) <b>20 years</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 day</b><br><b>20 years</b>   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>2/1/52</b> , 19 <b>52</b> , to <b>4/1/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/1/56</b> , 19 <b>56</b> , and that death occurred at <b>5:15 A.M.</b> , from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Stephen 2 Jan</b>   |  |  |  | DATE SIGNED <b>4/2/56</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Rockville Md</b>   |  |  |  | ADDRESS (Street, city or town, state)  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>4/4/56</b>        |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>   |  | 22d. LOCATION (City, town, or county) (State)                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Warren Talbot</b>  |  |  |  | ADDRESS <b>3619-14th St. N.W.</b>  |  |  |  |
| 24a. REC'D BY REGISTRAR <b>4-56</b>   |  |  |  | 24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>   |  |  |  |

CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text.

BUREAU V. S.

APR 6 1956

RECEIVED

Form with fields for signature, date, and other administrative details. Includes a large 'RECEIVED' stamp and a date stamp 'APR 6 1956'.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4272

## CERTIFICATE OF DEATH

04257

Reg. Dist. No. 215

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>18 days</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Ranier</b>  |                                  | 16-16-22   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>  |                                  | d. STREET ADDRESS<br><b>2901 Queens Chapel Road</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harold</b> Middle <b>Evan</b> Last <b>RICHARDSON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>15</b> Year <b>19 56</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>November 4, 1895</b> |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Government Employee</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Government</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Oregon</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   |
| 13. FATHER'S NAME<br><b>James G. RICHARDSON</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Jane D. HUGHES</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>WW-1 &amp; 2</b>  |   |
| 17. INFORMANT<br><b>2901 Queens Chapel Rd. Mt. Ranier, Md.</b>   |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma of the pharynx with metastases</b><br>148X DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>26 March, 1956</b> , to <b>15 April, 1956</b> , that I last saw the deceased alive on <b>15 April, 1956</b> , and that death occurred at <b>1120 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, and state) <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Robert L. King, Jr.</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Robert L. KING, Jr., CDR, MC, USN U.S. Naval Hospital, NNMC, Bethesda, Md.</b> |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>19 April 1956</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery Arlington, Virginia</b>   |                                  | 22d. LOCATION (City, town, or county) (State)  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. A. PUMPHREY FUNERAL HOME</b><br><b>7557 Wisconsin Ave., Bethesda, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE 4-16-56</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Russell</b>   |                                  |  |   |

CERTIFICATE OF DEATH

1956

|  |  |                                       |  |
|--|--|---------------------------------------|--|
| NAME OF DECEASED<br>JAMES H. HARRIS          |  | DATE OF DEATH<br>10/10/56             |  |
| PLACE OF DEATH<br>HOME                       |  | AGE<br>65                             |  |
| SEX<br>MALE                                  |  | RACE<br>WHITE                         |  |
| MANNER OF DEATH<br>NATURAL                   |  | CAUSE OF DEATH<br>HEART DISEASE       |  |
| DISEASE OR INJURY<br>CORONARY ARTERY DISEASE |  | PERIOD OF ILLNESS<br>2 WEEKS          |  |
| DATE OF BIRTH<br>10/10/1901                  |  | PLACE OF BIRTH<br>BALTIMORE, MD.      |  |
| OCCUPATION<br>RETIRED                        |  | EDUCATION<br>HIGH SCHOOL              |  |
| MARITAL STATUS<br>MARRIED                    |  | SPOUSE'S NAME<br>JANE HARRIS          |  |
| SIGNATURE OF DECEASED<br>(None)              |  | SIGNATURE OF WITNESSES<br>JANE HARRIS |  |

BUREAU V. S.

APR 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G196 1-20-56 et

CERTIFICATE OF DEATH

04258

Reg. Dist. No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Horners Lane</b>   |                                  | d. STREET ADDRESS<br><b>Horners Lane</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |
| 3. NAME OF DECEASED (Type or print) <b>EDWIN</b> First <b>G.</b> Middle <b>RIGGS</b> Last   |                                  | 4. DATE OF DEATH <b>April 11,</b> 19 <b>56</b> Month <b>April</b> Day <b>11</b> Year <b>1956</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 4, 1893</b> |
| 9. AGE (In years last birthday) <b>62</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>7</b> Hours <b></b> Min. <b></b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Fireman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Firefighting</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>George W. Riggs</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret C. Graham</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |   |
| 17. INFORMANT<br><b>Roger Bean-Rockville, Maryland</b>  |                                  | Address  |   |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure &amp; aspiration</b><br>154X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial pneumonia &amp; metastasis</b><br>DUE TO (c) <b>Carcinoma of rectum</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min.</b><br><b>2 weeks.</b><br><b>5 yrs.</b> |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>9/3/52</b> to <b>4/11/56</b> , that I last saw the deceased alive on <b>4/11/56</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>4/11/56</b><br>ACTUAL SIGNATURE <b>Stephen R. Jones</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Stephen R. Jones</b>  |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4/14/1956</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rockville Union</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Rockville Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE 4/16/56</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Laurel H. Bryant</b>   |                                  |  |   |

Maryland



CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| <p>1. NAME OF DECEASED<br/>                 [REDACTED]</p>        |  | <p>2. SEX<br/>                 [REDACTED]</p>                     |  |
| <p>3. AGE<br/>                 [REDACTED]</p>                     |  | <p>4. DATE OF BIRTH<br/>                 [REDACTED]</p>           |  |
| <p>5. PLACE OF BIRTH<br/>                 [REDACTED]</p>          |  | <p>6. PLACE OF DEATH<br/>                 [REDACTED]</p>          |  |
| <p>7. OCCUPATION<br/>                 [REDACTED]</p>              |  | <p>8. CAUSE OF DEATH<br/>                 [REDACTED]</p>          |  |
| <p>9. MEDICAL HISTORY<br/>                 [REDACTED]</p>         |  | <p>10. MANNER OF DEATH<br/>                 [REDACTED]</p>        |  |
| <p>11. SIGNATURE OF PHYSICIAN<br/>                 [REDACTED]</p> |  | <p>12. SIGNATURE OF REGISTRAR<br/>                 [REDACTED]</p> |  |
| <p>13. DATE OF DEATH<br/>                 [REDACTED]</p>          |  | <p>14. TIME OF DEATH<br/>                 [REDACTED]</p>          |  |
| <p>15. PLACE OF INTERMENT<br/>                 [REDACTED]</p>     |  | <p>16. NAME OF CEMETERY<br/>                 [REDACTED]</p>       |  |
| <p>17. NAME OF FUNERAL HOME<br/>                 [REDACTED]</p>   |  | <p>18. NAME OF FUNERAL HOME<br/>                 [REDACTED]</p>   |  |
| <p>19. NAME OF FUNERAL HOME<br/>                 [REDACTED]</p>   |  | <p>20. NAME OF FUNERAL HOME<br/>                 [REDACTED]</p>   |  |

BUREAU V. S.

APR 17 1956

RECEIVED

4/10/56 [Signature]

MAKING STATE DEPARTMENT OF HEALTH - BATHING, 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, and 6 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4273

## CERTIFICATE OF DEATH

04259  
216

Reg. Dist. No.

|  |                                  |  |  |   |   |
|--|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> b. COUNTY <b>47X-3</b> ✓ |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda, Maryland</b>  |                                  |  | c. LENGTH OF STAY IN 1b<br><b>22 days</b>  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>The Clinical Center, Bethesda, Md.</b>   |                                  |  | d. STREET ADDRESS<br><b>2915 Connecticut Avenue, Apt. 400</b>  |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lucy</b> Middle <b>Has</b> Last <b>Rowland</b>   |                                  |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>27</b> , Year <b>1956</b>  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>November 20, 1894</b>   | 9. AGE (In years last birthday)<br><b>61</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Government work</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Kansas</b>  |   |
| 13. FATHER'S NAME<br><b>Isaac Rowland</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Julia Garrow</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>not available</b>  |  | 17. INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda, 14, Maryland</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE LIVER NECROSIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>APLASTIC ANEMIA</b><br>DUE TO<br>(c) <b>CARCINOMA OF OVARIES WITH METASTASES</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |  |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH   |                                  |  |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. ft. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                |   |
| 20f. (City or town)  |                                  | 20g. (County)  |  | 20h. (State)  |   |
| 21. I certify that I attended the deceased from <b>April 5, 1956</b> , to <b>April 27, 1956</b> , that I last saw the deceased alive on <b>April 27, 1956</b> , and that death occurred at <b>1:55 A.M.</b> from the causes and on the date stated above.  |                                  |  |  |   |   |
| ACTUAL SIGNATURE <b>Horace Herbsman</b>  |                                  | M.D. <b>The Clinical Center</b>  |  | DATE SIGNED <b>4/27/56</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Horace Herbsman, M. D.</b>   |                                  | <b>National Institutes of Health<br/>Bethesda 14, Maryland</b>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>4/30/56</b>  |                                  | 22b. DATE THEREOF<br><b>4/30/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cemetery</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>Kansas City, Mo.</b>   |                                  | (State)<br><b>Kansas</b>   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co., 2901 14th St. N.W.</b>  |                                  | ADDRESS<br><b>Wash., D.C.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>4/30/56</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b>  |                                  |  |  |   |   |

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National Institutes of Health  
Bethesda, Maryland

The Clinical Center

and the death occurred in

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4167

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>3 hours</u>  |  |   |  | d. STREET ADDRESS <u>2407 Hannon St.</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>Joseph</u> Last <u>Rubino</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>22</u> Year <u>1956</u>  |  |  |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>cauc</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 8. DATE OF BIRTH <u>October 9 1917</u>                                 |  |
| 9. AGE (In years last birthday) <u>38</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Dist. Co.</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>D. C.</u>                 |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>John B. Rubino</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Mary Fiano</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <u>578-10-0136</u>   |  |  |  |
| 17. INFORMANT <u>Mrs. Josephine M. Rubino</u>   |  |   |  | Address <u>- same</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>DUE TO <u>  </u><br>(c) <u>Coronary artery Heart Disease</u> |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>April 22, 1956</u> , to <u>April 22, 1956</u> , that I last saw the deceased alive on <u>April 22, 1956</u> , and that death occurred at <u>9:00</u> M., from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Robert B. Irey</u>  |  |   |  | ADDRESS (Street, city or town, state) <u>7105 Riggs Rd., Hyattsville, Md.</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Robert B. Irey</u>   |  |   |  | DATE SIGNED <u>4-22-56</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>4/26/56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Golmar Manor, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u>   |  |   |  | ADDRESS <u>3200 R.I. Ave.</u>  |  | 24a. REC'D BY REGISTRAR <u>  </u>                                      |  |
| 24b. REGISTRAR'S SIGNATURE <u>  </u>  |  |   |  | DATE <u>4/26/56</u>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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4274

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

|  |                           |  |                                    |  |                                |   |                                |
|--|---------------------------|--|------------------------------------|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH  |                           |  |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                |   |                                |
| COUNTY MONTGOMERY  |                           | MARYLAND   |                                    | STATE MARYLAND   |                                | COUNTY MONTGOMERY   |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN WHEATON  |                           | LENGTH OF STAY (in this place)<br>1 YR.  |                                    | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN WHEATON                |                                |   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 2911 COLLINS AVENUE  |                           |  |                                    | STREET ADDRESS (If rural give location)<br>2911 COLLINS AVENUE                                       |                                |   |                                |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br>ANNIE MAY RUFFNER   |                           |  |                                    | 4. DATE OF DEATH (Month) (Day) (Year)<br>APRIL 12 19 56  |                                |   |                                |
| 5. SEX<br>FEMALE   | 6. COLOR OR RACE<br>WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>WIDOWED   | 8. DATE OF BIRTH<br>SEPT. 20, 1872 | 9. AGE last birthday<br>83 yrs.  | IF UNDER 1 YEAR<br>Months Days |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME  |                                    | 11. BIRTHPLACE (State or foreign country)<br>VIRGINIA  |                                | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                              |                                |
| 13. FATHER'S NAME<br>JOHN KING   |                           |  |                                    | 14. MOTHER'S MAIDEN NAME<br>EMMA MAE JANES   |                                |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)<br>NO   |                           | 16. SOCIAL SECURITY NO.<br>NONE  |                                    | 17. INFORMANT & ADDRESS<br>Mrs. Clarence E. Roberts,<br>2911 Collins Ave., Wheaton, Md.              |                                |   |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                           |  |                                    |  |                                | 18. MEDICAL CERTIFICATION   |                                |
| 420.1 IMMEDIATE CAUSE (A) Acute Coronary Infarction, septum of heart   |                           |  |                                    |  |                                | INTERVAL BETWEEN ONSET AND DEATH<br>1 day                           |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) Coronary Heart Disease  |                           |  |                                    |  |                                | June 19 55  |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis  |                           |  |                                    |  |                                |   |                                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                           |  |                                    |  |                                |   |                                |
| 19a. DATE OF OPERATION   |                           | 19b. MAJOR FINDINGS OF OPERATION   |                                    |  |                                |   |                                |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |  |                                    |  |                                |   |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                                    | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                                |   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)   |                           | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                    | 21f. HOW DID INJURY OCCUR?   |                                |   |                                |
| 22. I hereby certify that I attended the deceased from 6-13-1955, to April 12, 1956, that I last saw the deceased alive on April 12, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above. |                           |  |                                    |  |                                |   |                                |
| SIGNATURE <i>J. Hillman</i>  |                           |  |                                    | ADDRESS (Street, city, town, state) DATE SIGNED<br>M.D. 249 Missouri Avenue, N.W. Wash. D.C. 4-13-56 |                                |   |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |                           | DATE THEREOF<br>4/16/56  |                                    | NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CEMETERY   |                                | LOCATION (City, town, or county) (State)<br>PRINCE GEO. COUNTY, MD. |                                |
| 24. REC'D BY REGISTRAR<br>DATE 4/17/56   |                           | REGISTRAR'S SIGNATURE <i>Frances Collier</i>   |                                    | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey</i>   |                                | ADDRESS<br>SILVER SPRING, MD.                                       |                                |

## INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Form No. 10

IT BEING HEREBY CERTIFIED THAT THE DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

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BUREAU V. S.

APR 19 1956

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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THE INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME UNDER THE PENAL LAWS OF THE STATE OF MARYLAND.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04262

Reg. Dist. No.

214

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>montg</u>                          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>1 yr</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>1905 East West Highway</u>  |  |   |  | d. STREET ADDRESS<br><u>1905 East West Highway</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Estelle</u> Middle <u>Sammels</u> Last <u>Sammels</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>Apr</u> Day <u>24</u> Year <u>1956</u>   |  |  |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>8-12-93</u>   |  |
| 9. AGE (In years last birthday)<br><u>62</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>N.Y.C.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>N.Y.C.</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>MSC</u>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><u>Ralph Jacob</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Betha Wilson</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |  | 17. INFORMANT<br><u>Maurice Samuels (husband)</u> Address <u>same as dec'd</u>                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Central vascular accident</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |  |  |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>   |  | 20f. (City or town) (County) (State)<br><u>  </u>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>cremation</u>  |  |   |  | 22b. DATE THEREOF<br><u>4/25/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Crematory</u>                                       |  |
| 22d. LOCATION (City, town, or county) (State)<br><u>Pr. Geo. Co., Maryland</u>   |  |   |  |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>The S.H. Hines Co.</u>  |  |   |  | ADDRESS<br><u>Wash, 9, D.C.</u>   |  | 24a. REC'D BY REGISTRAR<br><u>4/25/56</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Francis J. Teller</u>   |  |   |  |   |  |  |  |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU NO. 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 30 1956  
BUREAU V. S.

4276

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Seneca</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Seneca</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>RFD # 1, Poolesville.</b>   |   | d. STREET ADDRESS<br><b>RDF # 1, Poolesville</b>   |   |
| 3. NAME OF DECEASED (Type or print) <b>ANNA</b> First Middle Last <b>SANCOMB</b>   |   | 4. DATE OF DEATH <b>April 9, 1956</b> Month Day Year   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-6-1893</b>   |
| 9. AGE (In years last birthday) <b>62</b> yrs.   |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>10</b> Days <b>3</b> Hours <b></b> Min. <b></b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Connecticut</b>             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |   |
| 13. FATHER'S NAME<br><b>George Storm</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Sullivan</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT Address<br><b>Howard G. Sancomb- Item # 2</b>                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>157X</b> IMMEDIATE CAUSE (a) <b>Hemorrhage</b><br>DUE TO (b) <b>Carcinoma Pancreas gland</b><br>DUE TO (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>6 months</b>      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none</b>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Sept 1955</b> to <b>April 1956</b> , that I last saw the deceased alive on <b>April 1956</b> , and that death occurred at <b>6:05 AM</b> , from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE <b>John Fawcett</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>P.O. Boyd, Md.</b> DATE SIGNED  |   |
| PHYSICIAN'S NAME (Type) <b>John Fawcett</b>  |   | <b>Boyd, Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>4-11-56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Rockville, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>DATE 4/10/56</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Lawell H. Bryant</b>                       |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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BUREAU V. S.

APR 11 1956

RECEIVED

James M. Thompson

5210117

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director, who should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04264

Reg. Dist. No. 218

|   |                                  |  |                                    |  |   |  |  |
|---|----------------------------------|--|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>monty</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg R-1</u>   |                                  | c. LENGTH OF STAY IN 1b  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg R-1</u>                        |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Goshen Rd.</u>   |                                  |  |                                    | d. STREET ADDRESS<br><u>Goshen Rd.</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Dale</u> Middle <u>Lee</u> Last <u>Santos</u>   |                                  |  |                                    | 4. DATE OF DEATH<br>Month <u>apr</u> Day <u>24</u> Year <u>1956</u>  |   |  |  |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2-14-56</u> |  | 9. AGE (in years last birthday)<br><u>2</u> yrs. <u>10</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)     |  |
| 10a. USUAL OCCUPATION   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>mass</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>usa</u>   |  |
| 13. FATHER'S NAME<br><u>Jos. Francis Santos Jr.</u>   |                                  |  |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Gladys Merrick (mother)</u> <u>same as</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT<br><u>same as item 14</u>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia due to vomiting</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Upper Respiratory Infection</u><br>DUE TO<br>(c) <u>—</u>  |                                  |  |                                    |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Found dead in bed</u>                                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |                                    |  |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |  |   |  |  |
| 20c. TIME OF INJURY<br>Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |  |                                    |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  |  |                                    | 22b. DATE THEREOF<br><u>April 24, 1956</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>GOSHEN</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Raymond Barber</u>   |                                  |  |                                    | ADDRESS<br><u>Laytonville, Md.</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>4-26-56</u>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Abner L. Cooke</u>   |                                  |  |                                    | 24c. DATE<br><u>4-26-56</u>  |   |  |  |

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BUREAU OF VITALS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 30 1956  
BUREAU V. S.

## 4278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

Items 8, 22b: film G196 5-1-56L

|   |                                  |   |                                     |   |   |   |   |
|---|----------------------------------|---|-------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                                  |   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>D.O.A.</u>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>                                     |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban Hospital</u>  |                                  |   |                                     | d. STREET ADDRESS<br><u>3253 23rd St., S.E.</u>   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edwa rd</u> Middle <u>P.</u> Last <u>Schaffer</u>   |                                  |   |                                     | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>1</u> Year <u>1956</u>  |   |   |   |
| 5. SEX<br><u>ma le</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4/8/1906</u> |   | 9. AGE (In years last birthday)<br><u>49</u> yrs. | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>9</u>  | IF UNDER 24 HRS.<br>Hours <u>19</u> Min.          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Accountant - Not employed</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Illinois</u>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><u>USA</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Evel Schaffer</u>   |                                  |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Ethel Bell</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No.</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>No.</u>   |                                     | 17. INFORMANT<br><u>Mrs. Victoria Schaffer</u> Address <u>3253-23rd St. S.E.</u>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                  |   |                                     |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  |   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .         |                                  |   |                                     |   |   |   |   |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.   |                                  |   |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>  |                                  |   |                                     | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
|   |                                  |   |                                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 22b. DATE THEREOF<br><u>4-15-56</u>   |                                     | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Holy Sepulchre</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Chicago</u>                                   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. William Lee &amp; Sons</u>  |                                  |   |                                     | 24a. REC'D BY REGISTRAR<br><u>4-5-56</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Bennie M. Thompson</u>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate, with the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

|                       |  |  |  |                         |  |                         |  |                                 |  |                |  |
|-----------------------|--|--|--|-------------------------|--|-------------------------|--|---------------------------------|--|----------------|--|
| NAME OF DECEASED      |  | AGE  |  | SEX                     |  | RACE                    |  | DATE OF DEATH                   |  | PLACE OF DEATH |  |
| JAMES H. HARRIS       |  | 45   |  | M                       |  | W                       |  | APR 8 1956                      |  | BALTIMORE, MD  |  |
| RESIDENCE             |  | OCCUPATION   |  | CAUSE OF DEATH          |  | MANNER OF DEATH         |  | SIGNATURE OF EXAMINER           |  | TITLE          |  |
| 1234 E. BALTIMORE ST. |  | LABORER  |  | HEART DISEASE           |  | NATURAL                 |  | J. H. HARRIS                    |  | M.D.           |  |
| PREVIOUS ILLNESS      |  | HISTORY OF PRESENT ILLNESS   |  | POST-MORTEM EXAMINATION |  | LABORATORY EXAMINATIONS |  | SIGNATURE OF ASSISTANT EXAMINER |  | TITLE          |  |
| NONE                  |  | Sudden onset of chest pain and shortness of breath, followed by loss of consciousness and death. |  | None performed.         |  | None performed.         |  | None                            |  | None           |  |
| FAMILY HISTORY        |  | SOCIAL HISTORY   |  | EDUCATION               |  | RELIGION                |  | MARRIAGE                        |  | CHILDREN       |  |
| None                  |  | None   |  | None                    |  | None                    |  | None                            |  | None           |  |

**BUREAU V. S.**  
 APR 9 1956  
**RECEIVED**



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor should execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04266  
4279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>1 1/2 hrs.</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>               |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>74 Suburban Hospital</u>   |                                  |   | d. STREET ADDRESS<br><u>11313 NORRIS DRIVE</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>FRANK Phillip Scherrer</u>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>4 - 4 19 56</u>  |   |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12-18-68</u>   |   | 9. AGE (In years last birthday)<br><u>87</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>gardener</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  |   |
| 13. FATHER'S NAME<br><u>Philip Scherrer</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>MARY Catherine Schrider</u>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>214-28-4989</u>   |   | 17. INFORMANT<br><u>Elana Quinter - Sister</u><br><u>11313 NORRIS DRIVE Kensington, Md.</u>                         |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><u>825X</u> DUE TO <u>Shock</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Multiple trauma by automobile</u><br>DUE TO <u>3 1/2 hrs.</u><br>(c) <u>3 1/2 hrs.</u>  |                                  |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Retro-peritoneal hemorrhage fracture humerus pelvis</u>   |                                  |   |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m.<br><u>7:03 am 4-4-56</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>11415 Chesmill Rd Silver Spring Md</u> |   |
| 20f. (City or town) (County) (State)<br><u>Silver Spring Md</u>   |                                  |   |   |   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |   |   |   |   |
| ACTUAL SIGNATURE<br><u>Frank J. Broschart</u> M.D.  |                                  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |
| EXAMINER'S NAME (Type)<br><u>FRANK J. BROSCART</u>  |                                  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |
|   |                                  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 22b. DATE THEREOF<br><u>4/7/56</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>ROCK CREEK CEMETERY</u>  |   |
|   |                                  |   |   | 22d. LOCATION (City, town, or county) (State)<br><u>WASHINGTON, D. C.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Warner E. Humphrey</u>   |                                  |   | ADDRESS<br><u>SILVER SPRING, MD.</u>  |   | 24a. REC'D BY REGISTRAR<br><u>DATE 4/7/56</u>   |
|   |                                  |   |   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Bessie M. Thompson</u><br><u>Per LH</u>                          |

RECEIVED

APR 9 1956

BUREAU V. S.

11513 Morris Drive Kensington, Md  
Sister - Sister  
Mild Catherine Schreiber

Harpland 11.2

12-12-68 81

Schreiber

11513 Morris Drive

Kensington

Harpland Maryland

Philip Schreiber

Harpland

White X

Frank Phil

Suburban Hospital

Beltsville Md

Harpland Maryland

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4280

## CERTIFICATE OF DEATH

Reg. Dist. No. 04267 216

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>1 month</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>SUSAN A.</u> Middle <u>Scoley</u> Last <u>Scoley</u>  |  |  |  | 4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1956</u>  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH <u>4-4-81</u>  |  |
| 9. AGE (In years last birthday) <u>75</u> yrs.   |  | IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u> |  | IF UNDER 24 HRS. Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Iowa</u>                   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u>   |  |  |  |   |  |   |  |
| 13. FATHER'S NAME <u>Vincent Dreyo</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Huldah Chidester</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <u>509-22-1181</u>  |  | 17. INFORMANT Address <u>Miriam Cunningham - SAME</u>                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Carcinoma of lung</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Smooth</u><br>DUE TO (c) <u>Smooth</u> |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smooth</u>  |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |  |  |  |   |  |   |  |
| 21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>56</u> , to <u>April 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>56</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>George Sharpe</u> M.D. <u>10644 Connecticut Ave</u>  |  |  |  | DATE SIGNED <u>4-10-56</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>George Sharpe</u> <u>Kensington, Md</u>   |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS &amp; BURIAL</u>  |  | 22b. DATE THEREOF <u>4/23/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>GREAT BEND CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>GREAT BEND, KANSAS</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>4-23-56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Beaumont Thompson</u>                     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

|                       |  |                          |  |                       |  |                           |  |                      |  |                            |  |                            |  |                           |  |
|-----------------------|--|--------------------------|--|-----------------------|--|---------------------------|--|----------------------|--|----------------------------|--|----------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED   |  | 2. SEX                   |  | 3. AGE                |  | 4. DATE OF BIRTH          |  | 5. PLACE OF BIRTH    |  | 6. OCCUPATION              |  | 7. MARITAL STATUS          |  | 8. COLOR                  |  |
| 9. DATE OF DEATH      |  | 10. TIME OF DEATH        |  | 11. PLACE OF DEATH    |  | 12. CAUSE OF DEATH        |  | 13. MANNER OF DEATH  |  | 14. SIGNATURE OF PHYSICIAN |  | 15. SIGNATURE OF REGISTRAR |  | 16. SIGNATURE OF WITNESS  |  |
| 17. NAME OF PHYSICIAN |  | 18. ADDRESS OF PHYSICIAN |  | 19. NAME OF REGISTRAR |  | 20. ADDRESS OF REGISTRAR  |  | 21. NAME OF WITNESS  |  | 22. ADDRESS OF WITNESS     |  | 23. NAME OF PHYSICIAN      |  | 24. ADDRESS OF PHYSICIAN  |  |
| 25. NAME OF PHYSICIAN |  | 26. ADDRESS OF PHYSICIAN |  | 27. NAME OF REGISTRAR |  | 28. ADDRESS OF REGISTRAR  |  | 29. NAME OF WITNESS  |  | 30. ADDRESS OF WITNESS     |  | 31. NAME OF PHYSICIAN      |  | 32. ADDRESS OF PHYSICIAN  |  |
| 33. NAME OF PHYSICIAN |  | 34. ADDRESS OF PHYSICIAN |  | 35. NAME OF REGISTRAR |  | 36. ADDRESS OF REGISTRAR  |  | 37. NAME OF WITNESS  |  | 38. ADDRESS OF WITNESS     |  | 39. NAME OF PHYSICIAN      |  | 40. ADDRESS OF PHYSICIAN  |  |
| 41. NAME OF PHYSICIAN |  | 42. ADDRESS OF PHYSICIAN |  | 43. NAME OF REGISTRAR |  | 44. ADDRESS OF REGISTRAR  |  | 45. NAME OF WITNESS  |  | 46. ADDRESS OF WITNESS     |  | 47. NAME OF PHYSICIAN      |  | 48. ADDRESS OF PHYSICIAN  |  |
| 49. NAME OF PHYSICIAN |  | 50. ADDRESS OF PHYSICIAN |  | 51. NAME OF REGISTRAR |  | 52. ADDRESS OF REGISTRAR  |  | 53. NAME OF WITNESS  |  | 54. ADDRESS OF WITNESS     |  | 55. NAME OF PHYSICIAN      |  | 56. ADDRESS OF PHYSICIAN  |  |
| 57. NAME OF PHYSICIAN |  | 58. ADDRESS OF PHYSICIAN |  | 59. NAME OF REGISTRAR |  | 60. ADDRESS OF REGISTRAR  |  | 61. NAME OF WITNESS  |  | 62. ADDRESS OF WITNESS     |  | 63. NAME OF PHYSICIAN      |  | 64. ADDRESS OF PHYSICIAN  |  |
| 65. NAME OF PHYSICIAN |  | 66. ADDRESS OF PHYSICIAN |  | 67. NAME OF REGISTRAR |  | 68. ADDRESS OF REGISTRAR  |  | 69. NAME OF WITNESS  |  | 70. ADDRESS OF WITNESS     |  | 71. NAME OF PHYSICIAN      |  | 72. ADDRESS OF PHYSICIAN  |  |
| 73. NAME OF PHYSICIAN |  | 74. ADDRESS OF PHYSICIAN |  | 75. NAME OF REGISTRAR |  | 76. ADDRESS OF REGISTRAR  |  | 77. NAME OF WITNESS  |  | 78. ADDRESS OF WITNESS     |  | 79. NAME OF PHYSICIAN      |  | 80. ADDRESS OF PHYSICIAN  |  |
| 81. NAME OF PHYSICIAN |  | 82. ADDRESS OF PHYSICIAN |  | 83. NAME OF REGISTRAR |  | 84. ADDRESS OF REGISTRAR  |  | 85. NAME OF WITNESS  |  | 86. ADDRESS OF WITNESS     |  | 87. NAME OF PHYSICIAN      |  | 88. ADDRESS OF PHYSICIAN  |  |
| 89. NAME OF PHYSICIAN |  | 90. ADDRESS OF PHYSICIAN |  | 91. NAME OF REGISTRAR |  | 92. ADDRESS OF REGISTRAR  |  | 93. NAME OF WITNESS  |  | 94. ADDRESS OF WITNESS     |  | 95. NAME OF PHYSICIAN      |  | 96. ADDRESS OF PHYSICIAN  |  |
| 97. NAME OF PHYSICIAN |  | 98. ADDRESS OF PHYSICIAN |  | 99. NAME OF REGISTRAR |  | 100. ADDRESS OF REGISTRAR |  | 101. NAME OF WITNESS |  | 102. ADDRESS OF WITNESS    |  | 103. NAME OF PHYSICIAN     |  | 104. ADDRESS OF PHYSICIAN |  |

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APR 25 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04268

4281

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |                                     |   |  |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>West Virginia</b> b. COUNTY                            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda, Maryland</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>31 days</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Martinsburg</b>  |                                     | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda, Md.</b>                                   |  |
| d. STREET ADDRESS<br><b>313 W. Race Street</b>  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Laura</b> Middle <b>Rosemargaret</b> Last <b>Shade</b>  |                                     | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>13</b> , Year <b>56</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 2, 1927</b>   |
| 9. AGE (In years last birthday)<br><b>29</b> yrs.   |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nurse</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>                              |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     | 13. FATHER'S NAME<br><b>Leo Rice</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Minnie Byer</b>  |                                     | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> If yes, give war or dates of service   |  |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                     | 17. INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Gastrointestinal hemorrhage, acute</b><br>DUE TO (b) <b>Thrombocytopenia</b><br>DUE TO (c) <b>Acute myeloblastic leukemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                     |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. 19  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |
| 20f. (City or town)   |                                     | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>March 13, 1956</b> , to <b>April 13, 1956</b> , that I last saw the deceased alive on <b>April 13, 1956</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.  |                                     |   |  |
| ACTUAL SIGNATURE<br><b>Martin Schick</b>  |                                     | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br><b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>                 |  |
| PHYSICIAN'S NAME (Type)<br><b>Martin Schick, M.D.</b>   |                                     | DATE SIGNED<br><b>H-13-56</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>4-16-56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Allegheny Co., Maryland</b>                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George Funeral Home</b>  |                                     | ADDRESS<br><b>Cumberland, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>DATE 4-16-56</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b>   |  |



APR 18 1956

RECEIVED

4282

MEDICAL CERTIFICATION

VS. A15ME(S)  
SM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                     |  |                |  |                |  |                 |  |                         |  |                 |  |                       |  |               |  |                |  |                |  |                  |  |                      |  |                        |  |                          |  |                          |  |               |  |
|-------------------------------------|--|----------------|--|----------------|--|-----------------|--|-------------------------|--|-----------------|--|-----------------------|--|---------------|--|----------------|--|----------------|--|------------------|--|----------------------|--|------------------------|--|--------------------------|--|--------------------------|--|---------------|--|
| NAME OF DECEASED                    |  | SEX            |  | AGE            |  | DATE OF BIRTH   |  | PLACE OF BIRTH          |  | OCCUPATION      |  | EDUCATION             |  | RELIGION      |  | MARRIAGE       |  | SINGLE         |  | MARRIED          |  | WIDOWED              |  | DIVORCED               |  | RE-MARRIED               |  | OTHER                    |  |               |  |
| JAMES H. HARRIS                     |  | MALE           |  | 35             |  | JAN 15 1920     |  | BALTIMORE, MD           |  | LABORER         |  | HIGH SCHOOL           |  | METHODIST     |  | MARRIED        |  | MARRIED        |  | MARRIED          |  | MARRIED              |  | MARRIED                |  | MARRIED                  |  | MARRIED                  |  |               |  |
| U.S. MARINE HOSPITAL, BALTIMORE, MD |  | BALTIMORE, MD  |  | BALTIMORE, MD  |  | BALTIMORE, MD   |  | BALTIMORE, MD           |  | BALTIMORE, MD   |  | BALTIMORE, MD         |  | BALTIMORE, MD |  | BALTIMORE, MD  |  | BALTIMORE, MD  |  | BALTIMORE, MD    |  | BALTIMORE, MD        |  | BALTIMORE, MD          |  | BALTIMORE, MD            |  | BALTIMORE, MD            |  |               |  |
| DATE OF DEATH                       |  | PLACE OF DEATH |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | DISEASE                 |  | SYMPTOMS        |  | TREATMENT             |  | HISTORY       |  | FAMILY HISTORY |  | SOCIAL HISTORY |  | PERSONAL HISTORY |  | PHYSICAL EXAMINATION |  | LABORATORY EXAMINATION |  | RADIOLOGICAL EXAMINATION |  | PATHOLOGICAL EXAMINATION |  |               |  |
| MAY 1 1956                          |  | BALTIMORE, MD  |  | HEART DISEASE  |  | NATURAL         |  | CORONARY ARTERY DISEASE |  | ANGINA PECTORIS |  | MYOCARDIAL INFARCTION |  | HYPERTENSION  |  | DIABETES       |  | SMOKING        |  | ALCOHOL          |  | PHYSICAL EXAMINATION |  | LABORATORY EXAMINATION |  | RADIOLOGICAL EXAMINATION |  | PATHOLOGICAL EXAMINATION |  |               |  |
| JAMES H. HARRIS                     |  | BALTIMORE, MD  |  | BALTIMORE, MD  |  | BALTIMORE, MD   |  | BALTIMORE, MD           |  | BALTIMORE, MD   |  | BALTIMORE, MD         |  | BALTIMORE, MD |  | BALTIMORE, MD  |  | BALTIMORE, MD  |  | BALTIMORE, MD    |  | BALTIMORE, MD        |  | BALTIMORE, MD          |  | BALTIMORE, MD            |  | BALTIMORE, MD            |  | BALTIMORE, MD |  |

BUREAU V. 3

MAY 2 1956

RECEIVED

4283

## CERTIFICATE OF DEATH

04270

Reg. Dist. No. 215

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>16.</b>                   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>  |  |  |  | c. LENGTH OF STAY IN 1b <b>14 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>  |  |  |  | d. STREET ADDRESS <b>1512 59th Avenue</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Albert</b> First <b>(n)</b> Middle <b>SMITH</b> Last   |  |  |  | 4. DATE OF DEATH <b>April</b> Month <b>20</b> Day <b>19 56</b> Year  |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>6-10-05</b>  |  |
| 9. AGE (In years last birthday) <b>50 yrs.</b>  |  | IF UNDER 1 YEAR Months <b>50</b> Days <b>16</b> Hours <b>x</b> Min. <b>2</b>                           |  | IF UNDER 24 HRS. Hours <b>16</b> Min. <b>x</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Mariner Retired</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>US</b>                                   |  |
| 13. FATHER'S NAME <b>Edward J. SMITH</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>   |  | 16. SOCIAL SECURITY NO. <b>WW II</b>   |  | 17. INFORMANT <b>Wife Mrs. Sarah G. SMITH</b>  |  | Address <b>Same as Item #2</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>156.1</b> <b>Stroke, Ruptured Aortic</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Subleptotic abscess</b><br>DUE TO<br>(c) <b>Adenocarcinoma, metastatic invasive</b>     |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs.</b><br><b>1 mo.</b><br><b>6 wks</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <b>6 Apr</b> , 19 <b>56</b> , to <b>20 Apr</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>20 Apr</b> , 19 <b>56</b> , and that death occurred at <b>11:27 PM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>USNH, NMHC, Bethesda, Maryland</b> DATE SIGNED <b>4-20-56</b> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>E. J. Rupnik</b>  |  | M.D. <b>USNH, NMHC, Bethesda, Maryland</b>   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>E. J. RUPNIK LCDR, MC, USN</b>   |  | USNH, NMHC, Bethesda, Maryland   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>24 Apr 56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Ryan Funeral Home</b>   |  |  |  | 24a. REC'D BY REGISTRAR <b>21 Apr 56</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Mary E. Parnell</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4284 CERTIFICATE OF DEATH

04271

Reg. Dist. No. 217

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp -</u>  |                                    | d. STREET ADDRESS <u>129 Grafton St.</u>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Alexander H. Sonnemann</u>  |                                    | 4. DATE OF DEATH Month Day Year <u>Apr - 26 1956</u>   |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W.</u>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 20 1871</u>                                   |
| 9. AGE (In years last birthday) yrs. <u>84</u>   |                                    | IF UNDER 1 YEAR Months Days Hours Min. <u>11 6</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Ottmar Sonnemann</u>  |                                    | 14. MOTHER'S MAIDEN NAME <u>Rebecca Cox</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                                    | 16. SOCIAL SECURITY NO. <u>None</u>  |   |
| 17. INFORMANT <u>patient</u>   |                                    | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>DUE TO (b) <u>Hypertensive cv disease + cardiac enlargement</u><br>DUE TO (c) <u>10 yrs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                    | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>April 15, 1956</u> , to <u>Apr 26, 1956</u> , that I last saw the deceased alive on <u>4/26/</u> , 19 <u>56</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.   |                                    |  |   |
| ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D.   |                                    | ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>4-26-56</u>  |   |
| PHYSICIAN'S NAME (Type) <u>John B. Ziegler</u>   |                                    | <u>Olney Maryland</u> <u>4-26-56</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>4-30-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>   | 22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>  |                                    | 24a. REC'D BY REGISTRAR <u>4-28-56</u> 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>  |   |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1951

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

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BUREAU V. S.

MAY 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04272

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>84 days</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Linthicum</b>  |                                  | d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>The Clinical Center, Bethesda, Md.</b>  |   |
| d. STREET ADDRESS<br><b>410 Forrestview Road</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Genevieve</b> Middle <b>Rictchie</b> Last <b>Stauffer</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>4</b> Year <b>56</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 16, 1902</b> |
| 9. AGE (In years last birthday)<br><b>53</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Lewis Rictchie</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Walker</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>The Medical Record</b>  |                                  | Address<br><b>The Clinical Center, Bethesda, Maryland</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Biliary nephrosis and hepatic coma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>metastatic breast cancer</b><br>DUE TO<br>(c) <b>Carcinoma, right breast</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>hemorrhagic diathesis due to thrombocytopenia</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>NONE</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>January 11, 1956</b> , to <b>April 4, 1956</b> , that I last saw the deceased alive on <b>April 4, 1956</b> , and that death occurred at <b>1:27 P.M.</b> , from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Robert S. Mendelsohn</b> M.D.  |                                  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br><b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>                 |   |
| DATE SIGNED<br><b>4/4/56</b>  |                                  |   |   |
| PHYSICIAN'S NAME (Type)<br><b>Robert S. Mendelsohn</b>  |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Apr. 7 1956</b>   |                                  | 22b. DATE THEREOF<br><b>Apr. 7 1956</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenhill</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Wilmington Del</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. G. Smith - 1217 St Paul St</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>APR 6 1956</b>  |   |
| ADDRESS<br><b>Paul St</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mrs. Susan Thompson</b>  |   |

MAYLAND, STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

RECEIVED

APR 6 1956

BUREAU V. 3

4286

CERTIFICATE OF DEATH

Reg. Dist. No. 214

|   |                                    |   |   |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>MONTGOMERY</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |   |
| c. LENGTH OF STAY IN 1b<br><b>2 YRS.</b>  |                                    |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>10,303 HAYWOOD DRIVE</b>   |                                    | d. STREET ADDRESS<br><b>1703 HIGHLAND DRIVE</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                    |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BERTHA</b> Middle <b>HOLT</b> Last <b>STEWART</b>   |                                    | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>27</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG. 31, 1862</b>  |
| 9. AGE (In years last birthday)<br><b>93</b> yrs.   |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>GERMANTOWN, PENNSYLVANIA</b>        |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |   |   |
| 13. FATHER'S NAME<br><b>CHALKLEY HOLT</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>RACHEL RITTENHOUSE</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   |
| 17. INFORMANT<br><b>MRS. CLIFFORD E. WALLER, 10303 Haywood Dr.</b>  |                                    | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dissecting abdominal aortic aneurysm</b><br><b>451X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Decompensation</b> |                                    |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>19 56</b> to <b>27 April, 19 56</b> , that I last saw the deceased alive on <b>27 April, 19 56</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.   |                                    |   |   |
| ACTUAL SIGNATURE <b>William D. Aud</b> M.D.   |                                    | DATE SIGNED <b>4/27/56</b>  |   |
| PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>   |                                    | <b>9006 COLESVILLE ROAD, SILVER SPRING, MD.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 22b. DATE THEREOF<br><b>5/1/56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>FRIENDS CEMETERY</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>MONTGOMERY COUNTY, MARYLAND</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wanner E. Humphrey</b>   |                                    | ADDRESS<br><b>SILVER SPRING, MD.</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>4/30/56</b>  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Frances Allen</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1956

|  |  |
|--|--|
| DECEASED<br>NAME<br>LAST FIRST MIDDLE<br>SEX<br>AGE<br>DATE OF BIRTH<br>PLACE OF BIRTH<br>RACE<br>COLOR<br>RELIGION<br>MARRIAGE<br>DATE OF MARRIAGE<br>PLACE OF MARRIAGE<br>OCCUPATION<br>DATE OF DEATH<br>PLACE OF DEATH<br>CAUSE OF DEATH<br>MANNER OF DEATH<br>SIGNATURE OF DECEASED<br>SIGNATURE OF WITNESS<br>SIGNATURE OF PHYSICIAN<br>SIGNATURE OF MINISTER<br>SIGNATURE OF CLERGYMAN<br>SIGNATURE OF CHURCH<br>SIGNATURE OF FUNERAL HOME<br>SIGNATURE OF BURIAL PLACE<br>SIGNATURE OF CEMETERY<br>SIGNATURE OF INTERMENT PLACE<br>SIGNATURE OF INTERMENT DATE<br>SIGNATURE OF INTERMENT TIME<br>SIGNATURE OF INTERMENT LOCATION<br>SIGNATURE OF INTERMENT ADDRESS<br>SIGNATURE OF INTERMENT CITY<br>SIGNATURE OF INTERMENT STATE<br>SIGNATURE OF INTERMENT ZIP CODE<br>SIGNATURE OF INTERMENT COUNTRY<br>SIGNATURE OF INTERMENT CONTINENT<br>SIGNATURE OF INTERMENT OCEAN<br>SIGNATURE OF INTERMENT ISLAND<br>SIGNATURE OF INTERMENT MOUNTAIN<br>SIGNATURE OF INTERMENT PLAIN<br>SIGNATURE OF INTERMENT DESERT<br>SIGNATURE OF INTERMENT TROPICS<br>SIGNATURE OF INTERMENT ARCTIC<br>SIGNATURE OF INTERMENT ANTARCTIC<br>SIGNATURE OF INTERMENT SPACE<br>SIGNATURE OF INTERMENT TIME<br>SIGNATURE OF INTERMENT DATE<br>SIGNATURE OF INTERMENT LOCATION<br>SIGNATURE OF INTERMENT ADDRESS<br>SIGNATURE OF INTERMENT CITY<br>SIGNATURE OF INTERMENT STATE<br>SIGNATURE OF INTERMENT ZIP CODE<br>SIGNATURE OF INTERMENT COUNTRY<br>SIGNATURE OF INTERMENT CONTINENT<br>SIGNATURE OF INTERMENT OCEAN<br>SIGNATURE OF INTERMENT ISLAND<br>SIGNATURE OF INTERMENT MOUNTAIN<br>SIGNATURE OF INTERMENT PLAIN<br>SIGNATURE OF INTERMENT DESERT<br>SIGNATURE OF INTERMENT TROPICS<br>SIGNATURE OF INTERMENT ARCTIC<br>SIGNATURE OF INTERMENT ANTARCTIC<br>SIGNATURE OF INTERMENT SPACE |  |
|--|--|

BUREAU V. E.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G196 5-7-56 et

4168

## CERTIFICATE OF DEATH

04274

Reg. Dist. No. 223

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>Stafford</u>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pileville</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>11 days</u>   |  |  |  | d. STREET ADDRESS <u>Wash San + Hosp</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>DELIA</u> <u>Stoneberger</u>  |  |  |  | 4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1956</u>   |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>11-15-1917</u>                                     |  |
| 9. AGE (In years last birthday) <u>34</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. Amer.</u>   |  |  |  |
| 13. FATHER'S NAME <u>Thomas Nicholas</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Nancy Nicholas</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congestive Cardiac Failure</u><br>DUE TO<br>(c) <u>Cerebral Hemorrhage</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>2 weeks</u><br><u>1 month</u> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>4-15-1956</u> , to <u>4-27-1956</u> , that I last saw the deceased alive on <u>4-26-1956</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>809 Davis Ave.,</u> DATE SIGNED <u>Takoma Park, Md.</u>  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.  |  |  |  | PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  |  | 22b. DATE THEREOF <u>4-29-56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Int. Union</u>                   |  |
| 22d. LOCATION (City, town, or county) <u>Pileville, Va.</u>  |  |  |  | (State) <u>Va.</u>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Shelby - Ivey, Va.</u>   |  |  |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR DATE <u>4/27/56</u>                            |  |
| 24b. REGISTRAR'S SIGNATURE <u>J. C. Shelby</u>   |  |  |  |  |  |  |  |

CERTIFICATE OF DEATH

4128

|                  |  |                 |  |                |  |                 |  |                   |  |                   |  |                    |  |                   |  |
|------------------|--|-----------------|--|----------------|--|-----------------|--|-------------------|--|-------------------|--|--------------------|--|-------------------|--|
| NAME OF DECEASED |  | SEX             |  | AGE            |  | DATE OF BIRTH   |  | PLACE OF BIRTH    |  | CITY OF BIRTH     |  | STATE OF BIRTH     |  | COUNTRY OF BIRTH  |  |
| JAMES EARL RAY   |  | M               |  | 35             |  | JAN 5 1928      |  | MEMPHIS           |  | TENNESSEE         |  | UNITED STATES      |  | UNITED STATES     |  |
| RACE             |  | COLOR           |  | RELIGION       |  | EDUCATION       |  | OCCUPATION        |  | MANNER OF DEATH   |  | CAUSE OF DEATH     |  | DISEASE OR INJURY |  |
| WHITE            |  | WHITE           |  | METHODIST      |  | HIGH SCHOOL     |  | LABORER           |  | SUICIDE           |  | GUNSHOT WOUND      |  | SUICIDE           |  |
| DATE OF DEATH    |  | PLACE OF DEATH  |  | CITY OF DEATH  |  | STATE OF DEATH  |  | COUNTRY OF DEATH  |  | DATE OF INTERMENT |  | PLACE OF INTERMENT |  | CITY OF INTERMENT |  |
| APR 4 1968       |  | MEMPHIS         |  | MEMPHIS        |  | TENNESSEE       |  | UNITED STATES     |  | APR 4 1968        |  | MEMPHIS            |  | MEMPHIS           |  |
| DATE OF REPORT   |  | PLACE OF REPORT |  | CITY OF REPORT |  | STATE OF REPORT |  | COUNTRY OF REPORT |  | DATE OF SIGNATURE |  | PLACE OF SIGNATURE |  | CITY OF SIGNATURE |  |
| APR 10 1968      |  | MEMPHIS         |  | MEMPHIS        |  | TENNESSEE       |  | UNITED STATES     |  | APR 10 1968       |  | MEMPHIS            |  | MEMPHIS           |  |

BUREAU V. S.

APR 30 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4287 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04275

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4927 Cordell Ave</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montg</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>d. STREET ADDRESS <u>4927 Cordell Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Esmond</u> First <u>Keyser</u> Middle <u>Sunday</u> Last<br><b>4. DATE OF DEATH</b> <u>Apr</u> Month <u>21</u> Day <u>1956</u> Year  |  |  |  | <b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>10-19-91</u> <b>9. AGE</b> (In years last birthday) <u>64</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Antique dealer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |  |  |  | <b>13. FATHER'S NAME</b> <u>Jacob G. Sunday</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth L. Smith</u>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)<br><b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Evangeline B. Sunday-Item # 2</u> Address   |  |  |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO <u>Strangulation</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulation</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>974X</u><br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck with 1/2 in rope</u><br><b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. p. m. Month, Day, Year <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>stone</u> <b>20f. (City or town)</b> <u>Bethesda</u> (County) <u>Montg</u> (State) <u>MD</u> |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/><br><b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Notural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCHE</u><br><b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u> <b>22b. DATE THEREOF</b> <u>4-24-56</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u> <b>22d. LOCATION (City, town, or county)</b> <u>Suitland, Maryland</u> (State)   |  |  |  | <b>24a. REC'D BY REGISTRAR</b> <u>4-22-56</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Beattie M. Thompson</u><br><b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey-Bethesda, Maryland</u> ADDRESS   |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

|                                  |  |                |  |                |  |                 |  |
|----------------------------------|--|----------------|--|----------------|--|-----------------|--|
| NAME OF DECEASED                 |  | SEX            |  | AGE            |  | DATE OF BIRTH   |  |
| JAMES H. HARRIS                  |  | M              |  | 45             |  | 11-15-11        |  |
| RESIDENCE                        |  | OCCUPATION     |  | CAUSE OF DEATH |  | MANNER OF DEATH |  |
| 1000 N. W. 10th St., Miami, Fla. |  | Police Officer |  | Heart Disease  |  | Natural         |  |
| DATE OF DEATH                    |  | PLACE OF DEATH |  | TIME OF DEATH  |  | TEMPERATURE     |  |
| 4-28-56                          |  | Home           |  | 10:00 AM       |  | 98.6            |  |
| SIGNATURE OF EXAMINER            |  | TITLE          |  | DATE           |  | PLACE           |  |
| J. H. HARRIS                     |  | Police Officer |  | 4-28-56        |  | Miami, Fla.     |  |

BUREAU V. S.

APR 28 1956

RECEIVED

NOTARY PUBLIC, Maryland



## CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH: 4288   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <i>Montgomery</i>  | MARYLAND  | STATE <i>Ind.</i>  | COUNTY <i>Montgomery</i>               |
| CITY (If outside corporate limits, write RURAL or and give nearest town) <i>Bethesda</i>  | LENGTH OF STAY (in this place) <i>1 wk 3 da</i> | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Alta Vista Rest Home</i>   |   | STREET ADDRESS (If rural give location) <i>6915 Strathmore st.</i>   |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <i>Benjamin Franklin Taylor</i>  |   | 4. DATE (Month) (Day) (Year) OF DEATH: <i>Apr. 13 1956</i>   |  |
| 5. SEX: <i>M</i>  | 6. COLOR OF RACE: <i>W</i>                      | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>  | 8. DATE OF BIRTH: <i>July 28, 1865</i> |
| 9. AGE last birthday: <i>90</i> yrs. <i>8</i> Months <i>15</i> Days <i></i> Hours <i></i> Min.  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired</i>   |  |
| 11. BIRTHPLACE (State or foreign country): <i>New Jersey</i>  |   | 12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>   |  |
| 13. FATHER'S NAME: <i>Mahlon Taylor</i>   |   | 14. MOTHER'S MAIDEN NAME: <i>Merciana Yardley?</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>  |   | 16. SOCIAL SECURITY NO. <i>None</i>  |  |
| 17. INFORMANT & ADDRESS: <i>Mrs. Ridgeway Taylor</i>  |   |  |  |
| 18. MEDICAL CERTIFICATION   |   |  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |   |  | INTERVAL BETWEEN ONSET AND DEATH       |
| IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>   |   |  | <i>3 days</i>                          |
| ANTECEDENT CAUSE (B)  |   |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)   |   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |   |  |  |
| 19A. DATE OF OPERATION: <i>0</i>  |   | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?  |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?  |   |  |  |
| 22. I hereby certify that I attended the deceased from <i>1/5/56</i> , 19....., to <i>4/13</i> ....., 1956 that I last saw the deceased alive on <i>4/13</i> ....., 1956, and that death occurred at <i>2:00 P.M.</i> from the causes and on the date stated above. |   |  |  |
| SIGNATURE <i>Dr. Joseph Kinnick</i>   |   | ADDRESS <i>M. D. 6450 Wisconsin Ave, Beth Md</i> DATE SIGNED <i>4/13/56</i>  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial-transit</i>  |   | DATE THEREOF <i>4/15/56</i>  |  |
| NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>   |   | LOCATION (City, town, or county) (State) <i>Burlington Co. New Jersey</i>  |  |
| DATE REC'D BY LOCAL REGISTRAR <i>4-16-56</i>  |   | REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>  |  |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>  |   | ADDRESS <i>Bethesda, Maryland</i>  |  |

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 18 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04227

Reg. Dist. No.

|   |  |   |                         |   |  |  |   |
|---|--|---|-------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>MONTGOMERY</b> MARYLAND   |  |   |                         | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |  |   | c. LENGTH OF STAY IN 1b |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOHN'S SCHOOL HALL</b>   |  |   |                         | d. STREET ADDRESS<br><b>1710 DONALD PLACE</b>   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HAROLD</b> Middle <b>S.</b> Last <b>TAYLOR</b>  |  |   |                         | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>14</b> Year <b>19 56</b>  |  |  |   |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |                         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12/5/13</b>   |   |
| 9. AGE (In years last birthday)<br><b>42</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days  |                         | IF UNDER 24 HRS.<br>Hours Min.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>  |  |   |                         | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Universal Pictures</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Dorchester, Mass.</b>                                    |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |                         |   |  |  |   |
| 13. FATHER'S NAME<br><b>HAROLD S. TAYLOR</b>  |  |   |                         | 14. MOTHER'S MAIDEN NAME<br><b>GRACE MEEHAN</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><b>012-10-2472</b>                   |                         | 17. INFORMANT<br>Address<br><b>Mrs. M. Loretta Taylor, 1710 Donald Place Silver Spring, Md.</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause lost. DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  |  |   |                         |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |                         |   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |                         |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |   |                         | 22b. DATE THEREOF<br><b>4/17/56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JOHN'S CEMETERY</b>   |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>MONTGOMERY COUNTY, MD.</b>  |  |   |                         |   |  |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Walter E. Humphrey</b>   |  |   |                         | 24a. REC'D BY REGISTRAR<br>DATE <b>4/17/56</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Frances Toller</b>  |   |

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

FRANK S. BROSCART

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4-14-56

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

APR 19 1956

RECEIVED

4169

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

|  |                               |  |                                 |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY                  |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park, Md</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3 ✓  |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Washington Sanitarium &amp; Hosp.</u>   |                               | d. STREET ADDRESS <u>3900-16th St N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>                           |                                 |
| 3. NAME OF DECEASED (Type or print) First <u>Mate</u> Middle <u>(no)</u> Last <u>Thurtell</u>  |                               | 4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1956</u>   |                                 |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-16-71</u> |
| 9. AGE (In years last birthday) <u>85 yrs.</u>   |                               | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>Iowa</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                 |
| 13. FATHER'S NAME <u>Charles Snow</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Maria Morrison</u>   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>  </u>  |                                 |
| 17. INFORMANT <u>Hospital Records</u>  |                               | Address <u>  </u>  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial failure Long Heart Failure</u><br>DUE TO (b) <u>Hypertensive Cardiac Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Nephritis</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>   |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Obesity - Chronic Bronchitis</u>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>56</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I attended the deceased from <u>April 13, 1956</u> to <u>April 19, 1956</u> , that I last saw the deceased alive on <u>April 18, 1956</u> , and that death occurred at <u>5:50</u> M., from the causes and on the date stated above.  |                               |  |                                 |
| ACTUAL SIGNATURE <u>Paul Eanet</u> M.D.  |                               | ADDRESS (Street, city or town, state) <u>6727-16th NW</u> DATE SIGNED <u>4-19-56</u>   |                                 |
| PHYSICIAN'S NAME (Type) <u>PAUL EANET M.D.</u>   |                               |  |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>  |                               | 22b. DATE THEREOF <u>4-28-56</u>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Seatons Md</u>  |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Funeral Home</u> ADDRESS <u>4812 Belview Rd</u>   |                               | 24a. REC'D BY REGISTRAR <u>J. J. Wilson</u> DATE <u>4/21/56</u>  |                                 |
| 24b. REGISTRAR'S SIGNATURE <u>J. J. Wilson</u>   |                               |  |                                 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4290

## CERTIFICATE OF DEATH

04279  
Reg. Dist. No. 276

|   |                                    |  |   |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4526 Drummond Ave</u>  |   |
| c. LENGTH OF STAY IN 1b <u>3 days</u>   |                                    | d. STREET ADDRESS <u>Cherry Chase, Md.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>  |                                    | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Elisabeth Winship Tibbott</u>  |                                    | 4. DATE OF DEATH April 7 1956  |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 19, 1863</u>                                       |
| 9. AGE (In years last birthday) <u>92</u> yrs.  |                                    | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME <u>Edward K. Winship</u>  |                                    | 14. MOTHER'S MAIDEN NAME <u>Carolyn Bachman</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>   |                                    | 16. SOCIAL SECURITY NO. <u>1</u>   |   |
| 17. INFORMANT <u>Son-Lloyd Tibbott - above</u>  |                                    | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumo, right lower lobe, with abscess</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                    |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia secondary to severe nephrosclerosis</u>   |                                    |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                    |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____  |                                    | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>4.1</u> , 1956, to <u>4.7</u> , 1956, that I last saw the deceased alive on <u>4.7</u> , 1956, and that death occurred at <u>4.50 PM</u> , from the causes and on the date stated above.   |                                    |  |   |
| ACTUAL SIGNATURE <u>Stewart Clapp</u>   |                                    | ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 3921 Ingomar St. N.W. Wash. D.C. 4.7.56</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>   |                                    |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  | 22b. DATE THEREOF <u>4/11/1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>   | 22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Maryland</u>  |                                    | 24a. REC'D BY REGISTRAR <u>DATE 4/10/56</u>  |   |
|   |                                    | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>   |   |



Reg. Dis. No. 042806

## MEDICAL CERTIFICATION

2

321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, symptoms, and examination findings. Includes checkboxes for various conditions and a large area for handwritten notes.

Form with checkboxes for cause of death and a large area for handwritten notes. Includes a section for the medical examiner's signature and date.

BUREAU V. S.

APR 20 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours, after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4292

CERTIFICATE OF DEATH

04281

Reg. Dist. No. 217

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>   |                           | c. LENGTH OF STAY IN 1b <u>2 yrs 1/2 mo</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burnt Mills</u>   |                           | d. STREET ADDRESS  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brook Grove Chronic Hosp</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William Tucker</u>   |                           | 4. DATE OF DEATH Month Day Year <u>April 29 1956</u>   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 25, 1866</u> |
| 9. AGE (In years last birthday) <u>89</u> yrs.  |                           | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Sandy Spring Md.</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>George Tucker</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Sarah Matilda Johnston</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                           | 16. SOCIAL SECURITY NO. <u>382-3821</u>  |  |
| 17. INFORMANT <u>Mrs W. Tucker</u>  |                           | Address <u>3821 Silver Spring Md.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis Left central artery</u><br>332X DUE TO <u>High Hematocrit</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u><br>DUE TO <u>pulmonary edema</u><br>(c) <u>Immature</u> |                           | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u><br><u>10 years 3 wks</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>May 10, 1938</u> , to <u>Apr 29, 1956</u> , that I last saw the deceased alive on <u>Apr 29, 1956</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.  |                           |  |  |
| ACTUAL SIGNATURE <u>Kenneth Laughlin</u>  |                           | ADDRESS (Street, city or town, state) <u>934 Eelsworth Rd Silver Spring Md</u>   |  |
| DATE SIGNED <u>4-29-56</u>  |                           | M.D. <u>and</u>  |  |
| PHYSICIAN'S NAME (Type) <u>KENNETH LAUGHLIN</u>   |                           |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>May 2, 1956</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Baptist</u>  |                           | 22d. LOCATION (City, town, or county) (State) <u>Burtonsville Md</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>  |                           | ADDRESS <u>Laytonsville Md.</u>  |  |
| 24a. REC'D BY REGISTRAR <u>DATE 4-30-56</u>   |                           | 24b. REGISTRAR'S SIGNATURE <u>Gertrude B Fowler</u>  |  |

1395  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Illegible]

2. DATE OF DEATH: [Illegible]

3. PLACE OF DEATH: [Illegible]

4. TIME OF DEATH: [Illegible]

5. CAUSE OF DEATH: [Illegible]

6. MANNER OF DEATH: [Illegible]

7. SIGNATURE OF DECEASED: [Illegible]

8. SIGNATURE OF WITNESS: [Illegible]

9. SIGNATURE OF PHYSICIAN: [Illegible]

10. SIGNATURE OF CORONER: [Illegible]

11. SIGNATURE OF MINISTER OF RELIGION: [Illegible]

12. SIGNATURE OF JUDGE: [Illegible]

13. SIGNATURE OF DISTRICT ATTORNEY: [Illegible]

14. SIGNATURE OF SHERIFF: [Illegible]

15. SIGNATURE OF CLERK: [Illegible]

16. SIGNATURE OF RECORDS MANAGER: [Illegible]

17. SIGNATURE OF CHIEF OF POLICE: [Illegible]

18. SIGNATURE OF MAYOR: [Illegible]

19. SIGNATURE OF GOVERNOR: [Illegible]

20. SIGNATURE OF PRESIDENT: [Illegible]

BUREAU V. 2

MAY 3 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04282 4293 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 211

|   |   |   |  |  |   |   |  |
|---|---|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Damascus</u>   |   | c. LENGTH OF STAY IN 1b<br><u>5 weeks</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Lakewood Park</u>                                 |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Mrs. Drake's Nursing Home</u>  |   |   |  | d. STREET ADDRESS<br><u>9 Jefferson Ave</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Aida</u> Middle <u>Walker</u> Last <u>Walker</u>  |   |   |  | 4. DATE OF DEATH<br>Month <u>Apr</u> Day <u>21</u> Year <u>1956</u>  |   |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan 1876</u>                                    | 9. AGE (In years last birthday)<br><u>80</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Ill</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Unknown</u>   |   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT<br><u>MRS. DRAKE</u>   |   | Address<br><u>DAMASCUS, Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____  |   |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u>                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |   |   |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)      |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |  |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |   |   |  | 22b. DATE THEREOF<br><u>APRIL 24, 1956</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>CEM RIGGS RD, HATTISVILLE PR GEO Co. Md.</u>             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Charles Stalling</u>   |   |   |  | 24a. REC'D BY REGISTRAR<br><u>APR 23 1956</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Lella H. Buntel</u>  |  |

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4-21-56

EXAMINER'S NAME (Type)

FRANK J. BROSCART

APR 23 1956

RECEIVED

4294

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

|  |                                  |  |                                    |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>                  |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Bethesda</i>  |                                  | c. LENGTH OF STAY IN 1b<br><i>6 days</i>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>74 Suburban</i>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Horace</i> Middle <i>Elsworth</i> Last <i>Wallik</i>   |                                  | 4. DATE OF DEATH<br>Month <i>April</i> Day <i>28</i> Year <i>1956</i>  |                                    |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><i>7-20-97</i> |
| 9. AGE (In years last birthday)<br><i>58 yrs.</i>  |                                  | 10. IF UNDER 1 YEAR<br>Months <i>58</i> Days <i>58</i> Hours <i>58</i> Min. <i>58</i>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Bus driver</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><i>Washington, D.C.</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |                                    |
| 13. FATHER'S NAME<br><i>Basil Crawford Wallik</i>  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Martha Bennett</i>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>(If yes, give war or dates of service)</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>Kenneth Wallik - son</i>   |                                    |
| 17. INFORMANT<br><i>Kenneth Wallik - son</i>   |                                  | Address  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial failure</i><br>DUE TO <i>410X</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Severe aortic and mitral valvulostenosis</i><br>DUE TO <i>Severe Rheumatic Heart Disease</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |  |                                    |
| INTERVAL BETWEEN ONSET AND DEATH   |                                  |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <i>19</i> p. m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <i>Sept</i> , 1954, to <i>Apr. 28</i> , 1956, that I last saw the deceased alive on <i>April 28</i> , 1956, and that death occurred at <i>4:50 P.M.</i> , from the causes and on the date stated above.  |                                  |  |                                    |
| ACTUAL SIGNATURE <i>Stewart Clapp</i>  |                                  | ADDRESS (Street, city or town, state) <i>3421 Ingomar St. N.W. Wash. D.C.</i>  |                                    |
| PHYSICIAN'S NAME (Type) <i>Stewart Clapp M.D.</i>  |                                  | DATE SIGNED <i>4.29.56</i>   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>4-5-56</i>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill</i>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><i>Landover Md.</i>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Ernest C. Gardner</i>   |                                  | ADDRESS<br><i>1111</i>   |                                    |
| 24a. REC'D BY REGISTRAR<br><i>5-1-56</i>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><i>Bennie M. Thompson</i>  |                                    |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1956

Page One of Two

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br><i>JOHN J. SMITH</i>        |  | 2. SEX<br><i>Male</i>  |  | 3. RACE<br><i>White</i>                            |  |
| 4. DATE OF BIRTH<br><i>10-15-1900</i>              |  | 5. PLACE OF BIRTH<br><i>St. Louis, Mo.</i>   |  | 6. US BIRTH REGISTRATION NO.<br><i>100-100000</i>  |  |
| 7. DATE OF DEATH<br><i>5-1-1956</i>                |  | 8. PLACE OF DEATH<br><i>Home</i>   |  | 9. CAUSE OF DEATH<br><i>Heart Disease</i>          |  |
| 10. MANNER OF DEATH<br><i>Natural</i>              |  | 11. INTERVIEWED<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 12. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 13. SIGNATURE OF WITNESSES<br><i>John J. Smith</i> |  | 14. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 15. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 16. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 17. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 18. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 19. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 20. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 21. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 22. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 23. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 24. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 25. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 26. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 27. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 28. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 29. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 30. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 31. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 32. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 33. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 34. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 35. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 36. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 37. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 38. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 39. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 40. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 41. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 42. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 43. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 44. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 45. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 46. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 47. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 48. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 49. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 50. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 51. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 52. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 53. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 54. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 55. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 56. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 57. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 58. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 59. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 60. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 61. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 62. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 63. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 64. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 65. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 66. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 67. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 68. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 69. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 70. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 71. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 72. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 73. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 74. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 75. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 76. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 77. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 78. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 79. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 80. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 81. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 82. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 83. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 84. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 85. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 86. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 87. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 88. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 89. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 90. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 91. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 92. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 93. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 94. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 95. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 96. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 97. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  | 98. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                      |  | 99. SIGNATURE OF DECEASED<br><i>John J. Smith</i>  |  |
| 100. SIGNATURE OF DECEASED<br><i>John J. Smith</i> |  | 101. SIGNATURE OF DECEASED<br><i>John J. Smith</i>                                     |  | 102. SIGNATURE OF DECEASED<br><i>John J. Smith</i> |  |

RECEIVED  
MAY 3 1956  
BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

04284

## 1. PLACE OF DEATH

County Montgomery County56 Village or City Silver Spring, MarylandNo. 9416 Worth AvenueSt. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

00 Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME

Mr. Allen Beckley Ward(a) Residence: No. 9416 Worth Avenue St. Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)Married5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofPearle Witter Ward6. DATE OF BIRTH (month, day, and year) July 30, 1884

7. AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.7183

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER  
SAWYER, BOOKKEEPER, etc.Construction Engineer9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.U. S. Government10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town) New York City  
(State or country) New York

FATHER

13. NAME

Moses Willson Ward14. BIRTHPLACE (city or town) Canaan,  
(State or country) Ohio

MOTHER

15. MAIDEN NAME

Rosalie A. Beckley16. BIRTHPLACE (city or town) Forestville  
(State or country) Connecticut

17. INFORMANT

Mrs. Pearle W. Ward(Address) 9416 Worth Ave., Silver Spring, Md.

18. BURIAL, CREMATION, OR REMOVAL

Trans. & EntombmentPlace Rural Cemetery  
Worcester, Mass.Date April 4, 19 56

19. UNDERTAKER

(Address) Warren & Pumphrey  
8434 Ga. Ave., Silver Spring, Md.

20. FILED

19 56

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

April  
(Month)3  
(Day)56  
(Year)22. I HEREBY CERTIFY, that I attended deceased, from  
August 7, 19 51, to April 3, 19 56I last saw him alive on April 3, 19 56; death is said  
to have occurred on the date stated above, at 3:50 PM.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Lobular Pneumonia, bilateralDate of onset  
4/17/56

Other Contributory Causes of importance:

Cancer, Prostatic - generalized  
metastasis5/27/55Name of operation ProstatectomyDate of 5/27/55What test confirmed diagnosis? Lab. Tissue SectionWas there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)  
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) Francis(Address) 3805 McKinley St. N.W., D.C. (15)

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

|                                       | Date of onset       |
|---------------------------------------|---------------------|
| <i>Arteriosclerosis</i>               | <i>1915</i>         |
| <i>Chronic interstitial nephritis</i> | <i>1921</i>         |
| <i>Cerebral hemorrhage</i>            | <i>July 5, 1927</i> |

Other contributory causes of importance:

|                   |                    |
|-------------------|--------------------|
| <i>Gallstones</i> | <i>May 1, 1923</i> |
|-------------------|--------------------|

## Example II

The principal cause of death and related causes of importance were as follows:

|                               | Date of onset     |
|-------------------------------|-------------------|
| <i>Attack of epilepsy</i>     | <i>1 week ago</i> |
| <i>Run over by street car</i> | <i>1 week ago</i> |
| <i>Peritonitis</i>            | <i>3 days ago</i> |

Other contributory causes of importance:

|                        |               |
|------------------------|---------------|
| <i>Gastroenteritis</i> | <i>1 year</i> |
|------------------------|---------------|

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

APR 9 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4296

## CERTIFICATE OF DEATH

04285  
Reg. Dist. No. 215

|   |  |   |   |   |   |   |  |  |
|---|--|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <b>District of Columbia</b> COUNTY <b>D.C.</b>            |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  |   | c. LENGTH OF STAY IN 1b<br><b>7 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NMMC, Bethesda, Md.</b>   |  |   |   | d. STREET ADDRESS<br><b>1430 Belmont St., N.W.</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Melciah</b> Middle <b>John</b> Last <b>WASHINGTON</b>   |  |   |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>22</b> Year <b>1956</b>   |   |   |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Negroid</b>        |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>Jan. 23, 1898</b>  |  |  |
| 9. AGE (In years last birthday)<br><b>58</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.  |   |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Resturant</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>                                 |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>WW-1</b>    |   | 17. INFORMANT<br><b>Mrs. Edna WASHINGTON, Wife (Same as #2)</b>   |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO <b>420.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary atherosclerosis</b><br>DUE TO<br>(c)  |  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>undetermined</b><br><b>6 1</b>                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>15 April</b> , 19 <b>56</b> , to <b>22 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>22 April</b> , 19 <b>56</b> , and that death occurred at <b>10:55P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-23-56</b><br>ACTUAL SIGNATURE <b>H. A. Schlang</b> M.D. <b>H. A. Schlang</b><br>PHYSICIAN'S NAME (Type) <b>H.A. SCHLANG, CDR, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b> |  |   |   |   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>4-27-56</b>       |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>                       |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. E. Jarvis</b><br><b>1430 Belmont St., N.W. Washington, D.C.</b>   |  |   |   | 24a. REC'D BY REGISTRAR<br><b>DATE 4-23-56</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Mary E. Russell</b>  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1956

|  |  |   |  |
|--|--|---|--|
| NAME OF DECEASED<br>JOHN J. BROWN      |  | DATE OF DEATH<br>JAN 15 1956                                  |  |
| PLACE OF DEATH<br>HOME                 |  | CITY<br>BALTIMORE   |  |
| COUNTY<br>BALTIMORE                    |  | STATE<br>MARYLAND   |  |
| AGE<br>65                              |  | SEX<br>MALE   |  |
| MARRIAGE<br>MARRIED                    |  | OCCUPATION<br>CLERK   |  |
| EDUCATION<br>HIGH SCHOOL               |  | RELIGION<br>CATHOLIC  |  |
| CAUSE OF DEATH<br>HEART DISEASE        |  | MANNER OF DEATH<br>NATURAL                                    |  |
| IMMEDIATE CAUSE<br>CORONARY THROMBOSIS |  | INTERMEDIATE CAUSE<br>HYPERTENSION                            |  |
| FUNDAMENTAL CAUSE<br>ARTERIOSCLEROSIS  |  | PREEXISTING DISEASES<br>HYPERTENSION, CORONARY ARTERY DISEASE |  |
| SIGNATURE OF PHYSICIAN<br>J. J. BROWN  |  | SIGNATURE OF WITNESSES<br>J. J. BROWN, J. J. BROWN            |  |
| DATE OF SIGNATURE<br>JAN 15 1956       |  | PLACE OF SIGNATURE<br>HOME                                    |  |
| NAME OF REGISTRAR<br>J. J. BROWN       |  | DATE OF REGISTRATION<br>JAN 15 1956                           |  |
| PLACE OF REGISTRATION<br>BALTIMORE     |  | COUNTY<br>BALTIMORE   |  |
| STATE<br>MARYLAND                      |  | FEDERAL BUREAU OF INVESTIGATION                               |  |

RECEIVED  
BUREAU V. 1  
APR 24 1956



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4297

CERTIFICATE OF DEATH

04286

Reg. Dist. No. 296

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bradley Farms, Bethesda</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bradley Farms, Bethesda</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>9306 Kendale Road</b>   |                                  | d. STREET ADDRESS<br><b>9306 Kendale Road</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth</b> Middle <b>Waterman</b> Last  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>17</b> Year <b>1956</b> <b>EX</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>June 10, 1901</b> |
| 9. AGE (In years last birthday)<br><b>54</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Nova Scotia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Canada</b> ✓   |  |
| 13. FATHER'S NAME<br><b>Rufus Parks</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Carrie Corkum</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>--</b>  |  |
| 17. INFORMANT<br><b>Arthur J. Waterman</b>   |                                  | Address<br><b>9306 Kendale Road Bethesda, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.0 DUE TO (b) <b>Coronary sclerotic Heart Disease</b> 10 yrs. (c) <b>Essential Arterial Hypertension</b> 15 yrs. 1 minute INTERVAL BETWEEN ONSET AND DEATH<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Apr 14, 1956</b> , to <b>Apr 17, 1956</b> , that I last saw the deceased alive on <b>4-13</b> , 19 <b>56</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Hill Carter</b>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>1835 Eye St NW 4-17-56</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>HILL CARTER</b>  |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4/19/1956</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Montgomery County, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S. W. Niles Co.</b>   |                                  | ADDRESS<br><b>2901 14th St. N.W. Washington 9, D.C.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>DATE 4-15-56</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4298

## CERTIFICATE OF DEATH

04287

Reg. Dist. No. 216

|  |                               |   |                                     |
|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |                               | c. LENGTH OF STAY IN 1b <b>4 days</b>   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hosp.</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cyrus</b> Middle <b>Watkins</b> Last <b>Watkins</b>  |                               | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>19 56</b>  |                                     |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Oct. ? 1884</b> |
| 9. AGE (In years last birthday) <b>71</b> yrs.   |                               | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur and Landscaping</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Aiken, S.C.</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?  |                                     |
| 13. FATHER'S NAME <b>Kimmy Watkins</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Jeanette Hallman</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO.   |                                     |
| 17. INFORMANT <b>Wife- Ella m. Watkins</b>   |                               | Address <b>above</b>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X massive cerebral hemorrhage</b><br>DUE TO (b) <b>rupture, left lenticulo-striate artery</b><br>DUE TO (c) <b>cerebral arteriosclerosis</b>  |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>7 days</b><br><b>10 years</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adenocarcinoma prostate</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                               | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I attended the deceased from <b>May 24</b> , 19 <b>56</b> , to <b>May 30</b> , 19 <b>56</b> that I last saw the deceased alive on <b>May 30</b> , 19 <b>56</b> , and that death occurred at <b>9:05 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Suburban Hosp. Bethesda 14 Md</b> DATE SIGNED <b>May 31</b><br>ACTUAL SIGNATURE <b>J. E. ASH</b><br>PHYSICIAN'S NAME (Type) <b>J. E. ASH</b> |                               |   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>May 4, 1956</b>  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>   |                               | ADDRESS <b>901 3rd Street, S. W.</b>  |                                     |
| 24a. REC'D BY REGISTRAR <b>5-4-56</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>R. W. Thompson</b>  |                                     |

CERTIFICATE OF DEATH

1956

|                       |  |                          |  |
|-----------------------|--|--------------------------|--|
| DATE OF DEATH         |  | PLACE OF DEATH           |  |
| MAY 4 1956            |  | BALTIMORE, MD.           |  |
| DECEASED'S NAME       |  | SEX                      |  |
| JAMES EARL RAY        |  | MALE                     |  |
| AGE                   |  | RACE                     |  |
| 35                    |  | WHITE                    |  |
| BIRTH DATE            |  | BIRTH PLACE              |  |
| MAY 12 1921           |  | MEMPHIS, TENN.           |  |
| OCCUPATION            |  | EDUCATION                |  |
| ATTORNEY              |  | HIGH SCHOOL              |  |
| MARRIAGE              |  | RELIGION                 |  |
| MARRIED               |  | METHODIST                |  |
| PREVIOUS MARRIAGES    |  | CAUSE OF DEATH           |  |
| NONE                  |  | HEART DISEASE            |  |
| IMMEDIATE CAUSE       |  | MORBID CAUSE             |  |
| MYOCARDIAL INFARCTION |  | CORONARY ARTERY DISEASE  |  |
| INTERVIEWED           |  | SIGNATURE OF PHYSICIAN   |  |
| YES                   |  | JAMES EARL RAY           |  |
| DATE OF INTERVIEW     |  | PLACE OF INTERVIEW       |  |
| MAY 4 1956            |  | BALTIMORE, MD.           |  |
| INTERVIEWED BY        |  | SIGNATURE OF INTERVIEWER |  |
| JAMES EARL RAY        |  | JAMES EARL RAY           |  |
| DATE OF INTERVIEW     |  | PLACE OF INTERVIEW       |  |
| MAY 4 1956            |  | BALTIMORE, MD.           |  |
| INTERVIEWED BY        |  | SIGNATURE OF INTERVIEWER |  |
| JAMES EARL RAY        |  | JAMES EARL RAY           |  |
| DATE OF INTERVIEW     |  | PLACE OF INTERVIEW       |  |
| MAY 4 1956            |  | BALTIMORE, MD.           |  |
| INTERVIEWED BY        |  | SIGNATURE OF INTERVIEWER |  |
| JAMES EARL RAY        |  | JAMES EARL RAY           |  |

BUREAU V. S.

MAY 4 1956

RECEIVED

4299

CERTIFICATE OF DEATH

04288

Reg. Dist. No. 217

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>                            |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>   |                               | d. STREET ADDRESS  |                                    |
| 3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Dorsey</u> Last <u>Watkins</u>                         |                               | 4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1956</u>  |                                    |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 5 1865</u> |
| 9. AGE (In years last birthday) <u>90</u> yrs.   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor &amp; Farmer</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                    |
| 13. FATHER'S NAME <u>John Thomas Watkins</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                               | 16. SOCIAL SECURITY NO. <u>✓</u>   |                                    |
| 17. INFORMANT <u>Hospital Record</u>   |                               | Address  |                                    |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease with</u><br><u>442X</u> DUE TO <u>Terminal uremia.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9020</u><br>(b) <u>Generalized arteriosclerosis</u><br>DUE TO<br>(c) <u>Terminal Broncho-pneumonia</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>25 yrs</u><br><u>25 yrs</u><br><u>1 week</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient fell out of bed 4 days prior to admission spraining</u>   |  |   |

|  |  |   |  |
|--|--|---|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>back</u><br><u>? Possible contributing cause.</u> |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>4 am</u><br>p. m. <u>3-21-56</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  | 20f. (City or town) (County) (State)<br><u>RFD Gaithersburg, Md.</u> |

21. I certify that I attended the deceased from March 21, 1956, to April 9, 1956, that I last saw the deceased alive on April 8, 1956, and that death occurred at 7:55a M, from the causes and on the date stated above.

ACTUAL SIGNATURE M. McKendree Boyer M.D. Damascus, Md.  
ADDRESS (Street, city or town, state) P. Druid Theatre Building, Damascus, Maryland  
DATE SIGNED

|   |  |   |   |
|---|--|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>                             | 22b. DATE THEREOF <u>April 12 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Providence Reformatory Md</u> | 22d. LOCATION (City, town, or county) (State) <u>Fredrick Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u> ADDRESS <u>Logtownville Md</u> |  | 24a. REC'D BY REGISTRAR <u>DATE 4-11-56</u>                         | 24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

APR 16 1953

RECEIVED

4300

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>75x-3</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenside</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>  |   | d. STREET ADDRESS <u>2209 Fair Hill Avenue</u>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Crichton</u> Last <u>Wetmore</u>   |   | 4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1956</u>   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-6-84</u>                                    |
| 9. AGE (In years last birthday) <u>71</u> yrs.  |   | IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u> Hours <u></u> Min. <u></u>  | IF UNDER 24 HRS. Hours <u></u> Min. <u></u>                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u></u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Robert Crichton</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Agnes Crichton</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <u>Unknown</u>   |   |
| 17. INFORMANT <u>husband</u> Address <u>Albert Wetmore</u>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u><br>DUE TO (c) <u></u>   |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u><br><u>10 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. <u>19</u><br>p. m. <u></u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                              |
| 21. I certify that I attended the deceased from <u>April 26</u> , 19 <u>56</u> , to <u>April 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>56</u> , and that death occurred at <u>5:35 P.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>10644 Conn Ave Kensington, Md.</u> DATE SIGNED <u>4-28-56</u> |   |  |   |
| ACTUAL SIGNATURE <u>George Sharpe</u>   |   | M.D. <u>10644 Conn Ave</u>   |   |
| PHYSICIAN'S NAME (Type) <u>George Sharpe</u>  |   | <u>Kensington, Md.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)                     |
| <u>Bur-transit</u>  | <u>4/28/56</u>  | <u>Whitemarsh Mem. Pk.</u>   | <u>Glenside Penna.</u>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>   |   | 24a. REC'D BY REGISTRAR <u>4-29-56</u>   | 24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |                                   |  |                                   |  |                                    |  |
|--|--|-----------------------------------|--|-----------------------------------|--|------------------------------------|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY    |  | 2. SEX<br>Male                    |  | 3. AGE<br>35                      |  | 4. DATE OF DEATH<br>May 1, 1968    |  |
| 5. PLACE OF DEATH<br>Baltimore, Maryland |  | 6. COUNTY<br>Baltimore            |  | 7. MARRIAGE<br>Married            |  | 8. OCCUPATION<br>None              |  |
| 9. CAUSE OF DEATH<br>Suicide by gunshot  |  | 10. MANNER OF DEATH<br>Homicide   |  | 11. PLACE OF BURIAL<br>None       |  | 12. SIGNATURE OF DECEASED<br>None  |  |
| 13. SIGNATURE OF PHYSICIAN<br>None       |  | 14. SIGNATURE OF CORONER<br>None  |  | 15. SIGNATURE OF WITNESS<br>None  |  | 16. SIGNATURE OF DECEASED<br>None  |  |
| 17. SIGNATURE OF DECEASED<br>None        |  | 18. SIGNATURE OF DECEASED<br>None |  | 19. SIGNATURE OF DECEASED<br>None |  | 20. SIGNATURE OF DECEASED<br>None  |  |
| 21. SIGNATURE OF DECEASED<br>None        |  | 22. SIGNATURE OF DECEASED<br>None |  | 23. SIGNATURE OF DECEASED<br>None |  | 24. SIGNATURE OF DECEASED<br>None  |  |
| 25. SIGNATURE OF DECEASED<br>None        |  | 26. SIGNATURE OF DECEASED<br>None |  | 27. SIGNATURE OF DECEASED<br>None |  | 28. SIGNATURE OF DECEASED<br>None  |  |
| 29. SIGNATURE OF DECEASED<br>None        |  | 30. SIGNATURE OF DECEASED<br>None |  | 31. SIGNATURE OF DECEASED<br>None |  | 32. SIGNATURE OF DECEASED<br>None  |  |
| 33. SIGNATURE OF DECEASED<br>None        |  | 34. SIGNATURE OF DECEASED<br>None |  | 35. SIGNATURE OF DECEASED<br>None |  | 36. SIGNATURE OF DECEASED<br>None  |  |
| 37. SIGNATURE OF DECEASED<br>None        |  | 38. SIGNATURE OF DECEASED<br>None |  | 39. SIGNATURE OF DECEASED<br>None |  | 40. SIGNATURE OF DECEASED<br>None  |  |
| 41. SIGNATURE OF DECEASED<br>None        |  | 42. SIGNATURE OF DECEASED<br>None |  | 43. SIGNATURE OF DECEASED<br>None |  | 44. SIGNATURE OF DECEASED<br>None  |  |
| 45. SIGNATURE OF DECEASED<br>None        |  | 46. SIGNATURE OF DECEASED<br>None |  | 47. SIGNATURE OF DECEASED<br>None |  | 48. SIGNATURE OF DECEASED<br>None  |  |
| 49. SIGNATURE OF DECEASED<br>None        |  | 50. SIGNATURE OF DECEASED<br>None |  | 51. SIGNATURE OF DECEASED<br>None |  | 52. SIGNATURE OF DECEASED<br>None  |  |
| 53. SIGNATURE OF DECEASED<br>None        |  | 54. SIGNATURE OF DECEASED<br>None |  | 55. SIGNATURE OF DECEASED<br>None |  | 56. SIGNATURE OF DECEASED<br>None  |  |
| 57. SIGNATURE OF DECEASED<br>None        |  | 58. SIGNATURE OF DECEASED<br>None |  | 59. SIGNATURE OF DECEASED<br>None |  | 60. SIGNATURE OF DECEASED<br>None  |  |
| 61. SIGNATURE OF DECEASED<br>None        |  | 62. SIGNATURE OF DECEASED<br>None |  | 63. SIGNATURE OF DECEASED<br>None |  | 64. SIGNATURE OF DECEASED<br>None  |  |
| 65. SIGNATURE OF DECEASED<br>None        |  | 66. SIGNATURE OF DECEASED<br>None |  | 67. SIGNATURE OF DECEASED<br>None |  | 68. SIGNATURE OF DECEASED<br>None  |  |
| 69. SIGNATURE OF DECEASED<br>None        |  | 70. SIGNATURE OF DECEASED<br>None |  | 71. SIGNATURE OF DECEASED<br>None |  | 72. SIGNATURE OF DECEASED<br>None  |  |
| 73. SIGNATURE OF DECEASED<br>None        |  | 74. SIGNATURE OF DECEASED<br>None |  | 75. SIGNATURE OF DECEASED<br>None |  | 76. SIGNATURE OF DECEASED<br>None  |  |
| 77. SIGNATURE OF DECEASED<br>None        |  | 78. SIGNATURE OF DECEASED<br>None |  | 79. SIGNATURE OF DECEASED<br>None |  | 80. SIGNATURE OF DECEASED<br>None  |  |
| 81. SIGNATURE OF DECEASED<br>None        |  | 82. SIGNATURE OF DECEASED<br>None |  | 83. SIGNATURE OF DECEASED<br>None |  | 84. SIGNATURE OF DECEASED<br>None  |  |
| 85. SIGNATURE OF DECEASED<br>None        |  | 86. SIGNATURE OF DECEASED<br>None |  | 87. SIGNATURE OF DECEASED<br>None |  | 88. SIGNATURE OF DECEASED<br>None  |  |
| 89. SIGNATURE OF DECEASED<br>None        |  | 90. SIGNATURE OF DECEASED<br>None |  | 91. SIGNATURE OF DECEASED<br>None |  | 92. SIGNATURE OF DECEASED<br>None  |  |
| 93. SIGNATURE OF DECEASED<br>None        |  | 94. SIGNATURE OF DECEASED<br>None |  | 95. SIGNATURE OF DECEASED<br>None |  | 96. SIGNATURE OF DECEASED<br>None  |  |
| 97. SIGNATURE OF DECEASED<br>None        |  | 98. SIGNATURE OF DECEASED<br>None |  | 99. SIGNATURE OF DECEASED<br>None |  | 100. SIGNATURE OF DECEASED<br>None |  |

BUREAU V. S.

MAY 1 1968

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE IS DEEMED TO HAVE BEEN DECEASED. THIS CERTIFICATE IS NOT VALID UNLESS IT IS SIGNED BY A PHYSICIAN OR A CORONER. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE IS DEEMED TO HAVE BEEN DECEASED. THIS CERTIFICATE IS NOT VALID UNLESS IT IS SIGNED BY A PHYSICIAN OR A CORONER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04290  
2/6

4371

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. LENGTH OF STAY IN IB <u>2 hrs. 25 min</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>   |  | d. STREET ADDRESS <u>409 Blandford St.</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>James Wesley Baby</u>   |  | 4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1956</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-7-56</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) yrs. <u>2</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u>25</u> Min <u>25</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>John Whitacre</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Wanda Smith</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <u>Father John Whitacre</u>  |  | Address <u>409 Blandford St. Rockville, Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity (approximately 5 months)</u><br>DUE TO (b) <u>776X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>776X</u><br>DUE TO (c) <u>776X</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>10:30 AM 4/7, 1956</u> , to <u>11 AM 4/7, 1956</u> , that I last saw the deceased alive on <u>4/7, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE <u>Audrey J. McDonald</u>   |  | M.D. <u>809 VIERS MILL RD ROCKVILLE, MD. 4/8/56</u>  |   |
| PHYSICIAN'S NAME (Type)  |  | DATE SIGNED  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Trans</u>  | 22b. DATE THEREOF <u>4-9-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Gravel Springs Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Star Tannery, Frederick Co., Va</u>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Pumphrey</u>  |  | ADDRESS <u>7557 Wisconsin Ave.</u>   |   |
| 24a. REC'D BY REGISTRAR <u>DATE 4/10/56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>   |   |

BOKEAD V. S.

7/11 11411 50 7/11 11411 50

RECEIVED

RECEIVED



4302

CERTIFICATE OF DEATH

Reg. Dist. No. 216

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>105 E. Lenox Street</b>  |                                     | d. STREET ADDRESS<br><b>105 E. Lenox Street</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>GERTRUDE</b> First <b>R.</b> Middle <b>WILLIAMS</b> Last   |                                     | 4. DATE OF DEATH <b>April 10,</b> Month <b>1956</b> Day Year   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec. 29, 1889</b>                                    |
| 9. AGE (In years last birthday) <b>66</b> yrs.  |                                     | 10. IF UNDER 1 YEAR <b>3</b> Months <b>11</b> Days   | 11. IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Tennessee</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Wm. Henry Robeson</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Indie Ferguson</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                     | 16. SOCIAL SECURITY NO. <b>None</b>  |  |
| 17. INFORMANT <b>L.L. Williams, Jr. - Item # 2</b>  |                                     | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized metastatic carcinoma</b><br><b>170X</b> DUE TO (b) <b>Carcinoma of left breast (anaplastic)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>8 years</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> |                                     |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>4-10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>about 3-5</b> , 19 <b>56</b> , and that death occurred at <b>430A</b> P.M. from the causes and on the date stated above.  |                                     |  |  |
| ACTUAL SIGNATURE <b>Charles A. Jarvis, Sr. Surgeon</b>  |                                     | DATE SIGNED <b>4-10-56</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Charles A. Jarvis</b>  |                                     | ADDRESS (Street, city or town, state) <b>U.S.P.H.S. Outpatient Clinic</b><br><b>4th &amp; D. St. S.W., Wash, D.C.</b>                                    |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>4-12-56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Md.</b>   |                                     | 24a. REC'D BY REGISTRAR<br><b>DATE 4/10/56</b>   |  |
|   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Bessie M. Thompson</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

4175

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>26 Rockville</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>100 Lewis Ave.</b>  |   | d. STREET ADDRESS<br><b>1002 Lewis Ave.</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>EMMA ELIZABETH</b> First Middle Last <b>WISEMAN</b>   |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>28</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 16, 1887</b>   |
| 9. AGE (In years last birthday) <b>69</b> yrs.   |   | IF UNDER 1 YEAR: Months <b>3</b> Days <b>12</b> Hours <b></b> Min. <b></b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>John Franklin Fuller</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Mrs. Jessie W. Broadhurst</b>  |   | Address <b>5919 Lone Oak Dr. Bethesda, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>asphyxia</b><br>DUE TO <b>350x</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Regurgitation of mucus due to paroxysm of swallowing mucus - Parkinsonism</b><br>(c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>12 hrs</b><br><b>5 yrs</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>2/11/1954</b> to <b>4/29/1956</b> , that I last saw the deceased alive on <b>4/28/1956</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.  |   |  |  |
| ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>4/29/56</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>  |   | <b>Rockville, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>5-1-56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Montgomery County, Md.</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |   | ADDRESS<br><b>Bethesda, Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>5/2/56</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Laurel H. Kraybill</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                   |  |                             |  |                             |  |                                |  |  |  |
|-----------------------------------|--|-----------------------------|--|-----------------------------|--|--------------------------------|--|--|--|
| NAME OF DECEASED<br>JOHN J. JAMES |  | AGE<br>45                   |  | SEX<br>M                    |  | RACE<br>W                      |  | DATE OF DEATH<br>MAY 3 1956            |  |
| PLACE OF DEATH<br>HOME            |  | CITY<br>BALTIMORE           |  | COUNTY<br>BALTIMORE         |  | STATE<br>MD                    |  | COUNTRY<br>USA                         |  |
| OCCUPATION<br>LABORER             |  | EDUCATION<br>HIGH SCHOOL    |  | MARRIAGE<br>M               |  | RELIGION<br>CATHOLIC           |  | CAUSE OF DEATH<br>HEART DISEASE        |  |
| DATE OF BIRTH<br>MAY 3 1911       |  | PLACE OF BIRTH<br>BALTIMORE |  | MOTHER'S NAME<br>JANE JAMES |  | FATHER'S NAME<br>JOHN J. JAMES |  | SIGNATURE OF DECEASED<br>JOHN J. JAMES |  |
| DATE OF DEATH<br>MAY 3 1956       |  | PLACE OF DEATH<br>HOME      |  | CITY<br>BALTIMORE           |  | COUNTY<br>BALTIMORE            |  | STATE<br>MD                            |  |
| OCCUPATION<br>LABORER             |  | EDUCATION<br>HIGH SCHOOL    |  | MARRIAGE<br>M               |  | RELIGION<br>CATHOLIC           |  | CAUSE OF DEATH<br>HEART DISEASE        |  |
| DATE OF BIRTH<br>MAY 3 1911       |  | PLACE OF BIRTH<br>BALTIMORE |  | MOTHER'S NAME<br>JANE JAMES |  | FATHER'S NAME<br>JOHN J. JAMES |  | SIGNATURE OF DECEASED<br>JOHN J. JAMES |  |

BUREAU V. S.

MAY 3 1956

RECEIVED

2/12/56 James M. H. H. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04293

Reg. Dist. No.

216

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>md</u> b. COUNTY <u>montg</u>                          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b<br><u>D.O.A.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>74 Suburban Hosp</u>   |  |   |  | d. STREET ADDRESS<br><u>316 N. Washington St</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edward</u> Middle <u>Clayton</u> Last <u>Word</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>Apr</u> Day <u>15</u> Year <u>1956</u>   |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>Col</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Sept 14 1871</u>   |  |
| 9. AGE (In years last birthday)<br><u>84</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Labore</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>D.C. Govt</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>md</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Edward Word Sr</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ellen Russell</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><input type="checkbox"/>  |  | 16. SOCIAL SECURITY NO.<br><input type="checkbox"/>   |  | 17. INFORMANT<br><u>Mr &amp; Mrs Word 196 Martin Dr. Rockville md</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>  </u><br>(a), stating the underlying cause lost. DUE TO (c) <u>  </u>  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u><br>Month, Day, Year <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | <u>4-15-56</u>  |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>4/19/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Haiti</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Rockville, Md.</u>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert L. Snowden</u>  |  |   |  | ADDRESS<br><u>Rockville, Md.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>4/21/56</u>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Bessie M. Thompson</u>   |  |   |  |



WARRAND STATE DEPARTMENT OF HEALTH—BIRMINGHAM

4170

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

|   |                               |  |                                 |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wakoma Park</u>           |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>     |                               | d. STREET ADDRESS <u>606 Greenbrier Drive</u>  |                                 |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Frank</u> Middle <u>Frederick</u> Last <u>Wood</u>            |                               | 4. DATE OF DEATH<br>Month <u>4</u> - Day <u>14</u> Year <u>1956</u>  |                                 |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>9-11-05</u> |
| 9. AGE (In years last birthday) <u>50</u> yrs.  |                               | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>  |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                 |
| 13. FATHER'S NAME <u>Frank E. Wood</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Marion Dohman</u>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>                                  |                               | 16. SOCIAL SECURITY NO. <u>  </u>  |                                 |
| 17. INFORMANT <u>Hospital Records</u>   |                               | Address <u>  </u>  |                                 |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>148X ASPHYXIATION</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>CARCINOMA OF THE THROAT</u><br>DUE TO<br>(c) <u>  </u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>UNKNOWN</u><br><u>7 mos. +</u>                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MALNUTRITION</u>  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. <u>  </u> p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |
| 20f. (City or town)  |  | (County) (State)   |
| 21. I certify that I attended the deceased from <u>1949</u> to <u>APR. 14, 1956</u> , that I last saw the deceased alive on <u>APR. 13, 1956</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.   |  |  |
| ACTUAL SIGNATURE <u>L. Marshall Cuvillier, Jr.</u> M.D.  |  | ADDRESS (Street, city or town, state) DATE SIGNED  |
| PHYSICIAN'S NAME (Type) <u>L. Marshall Cuvillier, Jr.</u> <u>1407-1409 Woodside Pkwy. Silver Spring, Maryland</u>  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 22b. DATE THEREOF <u>4/16/56</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>                                  |
| 22d. LOCATION (City, town, or county) <u>PRINCE GEO. COUNTY, MARYLAND</u>  |  | (State)  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner &amp; Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>  |  | 24a. REC'D BY REGISTRAR <u>4-16-56</u>   |
| 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4304

## CERTIFICATE OF DEATH

04295

Reg. Dist. No. 214

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>6 YRS</b>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1303 MONTGOMERY STREET</b>  |                                  | d. STREET ADDRESS<br><b>1303 MONTGOMERY STREET</b>  |                                    |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EIMIRA</b> Middle <b>E.</b> Last <b>Zeidler</b>  |                                  | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>14</b> Year <b>19 56</b>  |                                    |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/25/84</b> |
| 9. AGE (In years last birthday)<br><b>72</b>   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>PHILADELPHIA, PA.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>JOHN BEAR</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>EMMA BEAR</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>YES</b>  |                                    |
| 17. INFORMANT<br>Mrs. Edna M. Weidler, 1303 Montgomery St.<br>Silver Spring, Md.   |                                  | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinomatosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Carcinoma of Colon</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from <b>11/9</b> , 19 <b>53</b> , to <b>4/14</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Apr. 9</b> , 19 <b>56</b> , and that death occurred at <b>1 P.</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>113 CARROLL ST NW WASH., DC</b> DATE SIGNED <b>4/14/56</b>  |                                  |   |                                    |
| ACTUAL SIGNATURE <b>Dean H. Harding</b>  |                                  | M.D. <b>113 CARROLL ST NW WASH., DC</b>   |                                    |
| PHYSICIAN'S NAME (Type) <b>DEAN H. HARDING</b>   |                                  |   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>4/20/56</b>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR LAWN CEMETERY</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>LANCASTER, PA.</b>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner E. Humphrey</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>4/17/56</b>  |                                    |
| ADDRESS<br><b>SILVER SPRING, MD.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Flance Teller</b>  |                                    |

Dr Brochant, Montgomery Co.,  
Cormer, notified and  
will approve.

Leah Harding

RECEIVED

APR 19 1936

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 118